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ABSTRACT

This report presents an experiment in post-graduate training of mental health professionals through innovative education designed not only to inform but to produce changes in individual attitudes, roles, and skills, as well as in agency programs. The educational design was based on a human factors or sociocentric change model. Included in Part One is a summary of project activities with specifics on the goal, the educational model, the participants, the outcomes, and the evaluation of the training project. Major impacts are noted on individuals, agencies, and on relationships between agencies. Based on material from rating scales and interviews, there was in increased acceptance of the goals of community mental health, an expanded definition of the field, and a greater sense of professional responsibility. Part Two of the report provides a detailed description of the curriculum and program, including lists of staff and participants. The appendix provides a followup questionnaire and reference material. (Author/KJ)

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COMMUNITY

CREATIVITY

COLLABORATION

A NEW TRAINING MODEL IN MENTAL HEALTH

A Summary Report On

THE COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT*

CASE WESTERN RESERVE UNIVERSITY
Cleveland College
Allan F. Pfleger, Dean

Cleveland, Ohio 44106

June, 1970

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COMMUNITY
CREATIVITY
COLLABORATION

A New Training Model in Mental Health

The temporary system which shared community, creativity and collaboration through the years 1967-1969 consisted of:

STAFF: Elaine Kepner, Cynthia Harris, Joseph Handlon, Rose Stevenson

ASSOCIATES: William Arnold, Frances Baker, Arthur Blum, Lois Brien, Steven Fink, Magdalena Miranda, William Warner.

GRADUATE STUDENTS: Frances Baker, Hans Daumer, Robert Gordon, Robert Knappenberger, David Phoenix, Robert Sprague, Carl Weitman.

PARTICIPANTS: Sonia Abels, Myrtle Astrachan, Barbara Ballard, Jankiel Barg, Robert Batman, Alice Beck, Albert Becker, D. Marshall Begley, Miriam Birnbaum, Luther Bishop, Gloria Blackmon, Lynn Brallier, Mary Brumbach, Kathleen Burton, Madeline Cargill, Terry Chevers, Penelope Cloud, Robert Conquest, Thomas Diederich, Irma Dixon, Viola Evans, Father Jesse Fratus, Luz Fuentez, Kathleen Geathers, Arthur Goldfarb, Marvin Gottlieb, Howard Grenell, William Grover, Leonard Haas, Marjorie Hall, Jean Harris, Clyde Harrison, Mary Hartzell, William Hayne, Rev. John Herman, Roger Hess, Emily Hibshman, Clifford Hickox, Virginia Hogan, Donald Hoyt, Toaru Ishiyama, Helen Jenkins, Sister Marilyn Jerzy, Thomas Joynes, Roberta Klein, Antonia Kurent, James Kuth, Madeline Laux, Dale Leverett, Josie Lindsay, Gordon Loomis, Linda Loveland, Philomena Luczek, Ann Matz, Milton Matz, Harold McCormick, Loretta Mersy,

Steven Minter, Simon Miranda, Thomas Nemeth, Helen Panek, Jean Patterson, Phyllis Peterson, Dorothy Purser, Faye Ratner, Glenn Roderick, Rev. Charles Ronkos, Irving Rosen, Ruth Rosen, Anna Ross, Eileen Rubin, Anne Schaffner, Anne Schwartz, Richard Schwartz, Samuel Selekman, Mildred Shelley, Helen Spears, James Spencer, Joseph Stanley, Julia Starr, Kathleen Stoll, David Strand, Paul Straub, Murtis Taylor, Cornelius Utz, Marilyn Vance, Charlotte Van Stolk, Charles Vogt, Calvert Walker, Eleanor Warner, William Warner, Effie Warren, Richard White, J. Richard Ziegler.

ACKNOWLEDGEMENTS

This program represents the combined efforts of many people. Recognition is due the twenty-eight agency directors who gave initial support by releasing the time of ninety-four of their staff to attend the training sessions.

The participants themselves deserve special recognition for their continuing interest and commitment to this experimental training design and for their ability to bear the confusions and anxieties of this new participative-learning model.

Sincere appreciation is expressed to all of those at Cleveland College who nurtured this project from the time of the initial drafting through the completion of the project. Of particular importance were Allan F. Pfleger, Dean of Cleveland College and Melvin Allerhand, who was Director of the Division of General Studies at Cleveland College. Both assisted in the drafting of the original proposal and continued on as consultants and advisors. Sherwood Greenfield and his staff provided us with valuable administrative support.

A number of other persons with special expertise about community mental health in Cleveland served as informal consultants, especially in the early phases of this program. Noteworthy in this regard were: Mr. H. Bernard Smith, who was the Executive Secretary of the Cleveland Mental Health Planning Committee of the Cleveland Welfare Federation (presently the Executive Director of the Cuyahoga County Community Mental Health and Retardation Board); William Heston, Ph.D., Provost, Case Western Reserve University and Chairman, Cleveland Mental Health Planning Committee; George Albee, Ph.D., Professor, Department of Psychology, Case Western Reserve University.

A note of thanks also goes to those friends and advisors who helped in the design of the educational model, among whom were Erving Polster, Ph.D., Director of Post-Graduate Training, Gestalt Institute of Cleveland; Edwin Nevis, Ph.D., of Nevis, Wallen Associates of Cleveland, Ohio; and Richard Beckhard, Professor, Sloan School of Management, Massachusetts Institute of Technology.

Several associated with us in the training project deserve special mention. Lois Brien, Ph.D., was given release time from the Department of Speech Communication of Case Western Reserve University to staff the project; Frances Baker, M.A., and Robert Knappenberger, M.A., graduate students were assigned to us by the Department of Psychology, Case Western Reserve University. They gave of themselves above and beyond the call of duty.

On behalf of the staff and the participants, we convey our appreciation to those in the Experimental and Special Training Grants Section of the National Institute of Mental Health whose support made this demonstration program in continuing education possible.

Kurt Lewin, an outstanding theoretician in the field of applied behavioral science once said, "if you want to understand a system, try to change it". This project enabled the staff and participants to broaden our understanding of community mental health through our attempts to change the system and . . . ourselves.

COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT

SUMMARY REPORT

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Part One

SUMMARY OF PROJECT ACTIVITIES OVERVIEW

PART ONE - OVERVIEW

OUR HOPES AND AIMS

When the moon is in the seventh house
and Jupiter abides with Mars
then peace will guide the planets
and love will guide the stars

This is the dawning of the Age of Aquarius
Age of Aquarius, Aquarius, Aquarius.

Harmony and understanding
sympathy and trust abounding
No more falsehoods or derisions
mystic crystal revelation
and the mind's true liberation

Aquarius, Aquarius, Aquarius.

The 1960's may be viewed by historians as the dawning of the Age of Aquarius in mental health. To paraphrase the lyrics from the musical HAIR*, the dream or vision was the hope that help could be provided to all in need of mental health services; that there would be harmony and understanding between all of the federal, state and local agencies; that sympathy and trust would abound between and among the professions - all this resulting in "the mind's true liberation" for the client population. The Federal government ushered in this age of hope and creativity with the enactment of the 1963 Community Mental Health Centers Act.

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* HAIR, book and lyrics by Gerome Ragno and James Rado

Calling for "a bold new approach", this legislation provided funds for new facilities, new types of preventive programs and funds to train those who would be staffing and implementing them.

This report is about a training project supported by the National Institute of Mental Health from 1967 through 1970 and administered through Cleveland College of Case Western Reserve University. It is the story of a "bold new approach" in post-graduate training of mental health professionals -- an experiment in innovative education designed not only to inform, but to produce changes in individuals' attitudes, roles and skills as well as in agency programs. This educational program ran for two years; each year a different multi-disciplinary group came together for 30 weekly 3-hour sessions, and four 2-day workshops spaced at bi-monthly intervals. During the two years of the program, 94 mental health professionals, (social workers, psychiatrists, psychologists, nurses, etc.) representing 28 agencies, were trained.

In a real sense, we wanted to "turn on" mental health professionals to the enormous challenge and potentials in the new field of community mental health by creating a learning community in which people would be able to explore new concepts and ideas, confront their stereotypes, understand their resistances to change, and generally become more free and open with each other in the interest of finding viable solutions to the problems of community mental health.

Our "bold new approach" in training was unique both with respect to our goal, which was to produce organizational change, and with respect to our educational design, which was based on a human factors or sociocentric change model.

GOAL OF ORGANIZATIONAL CHANGE

In contrast to most of the post-graduate training programs in which the focus is solely on the continuing education of the individual professional, our aim was to produce organizational changes within the institutions from which the participants were drawn and to encourage the development of inter-agency coordination and collaboration. Further, it was our hope that the participants would be encouraged to play a more active role in the mental health planning process which was still in the embryonic stages in Cleveland.

Organizational change, like individual change, requires a diagnosis of the total situation. This next section deals with our impressions of the situation as it existed at the time the project began. First, we will discuss the state of the local mental health service system as we saw it, and second, the state of mind of the professionals in the system. We regarded the latter as particularly important, since system changes are, in the final analysis, made or resisted by the people in them.

Our Diagnosis of the System

As in many other communities throughout this country, mental health services in Cleveland were carried out by a number of unconnected and overlapping systems. First, there were many private agencies with long histories of service. Their primary link to each other was through the fact that they were funded, wholly or in part, by the Welfare Federation of Cleveland, the local United Appeal organization. Next, there were a number of public agencies and institutions representing local, county and state governments, again with a minimum of coordination. The system as a whole, displayed the following characteristics typical of mental health service systems in most urban areas:

. . . . . isolation of the parts from each other as evidenced by poor communication and lack of coordination of efforts between and within agencies

. . . . . competition for scarce resources of money, manpower, space, status and power

. . . . . inability to accomplish the organizational mission of effectively reaching those most in need of help

. . . . . lack of ability to shift from traditional treatment strategies to those which would extend coverage, such as family therapy, group methods and utilization of para-professionals.

On the planning level, the community was just beginning to mobilize itself. At the time the training program was funded (in the spring of 1967), Cleveland had completed the first stage of the planning process required by the federal government in order to become eligible for federal funding. A survey of needs and resources had been published by the Comprehensive Mental Health Planning Committee of the Welfare Federation of Cleveland under the title, "Interaction for Mental Health". In this report, there was much talk of the mental health crisis, but little mention of the inefficient, fragmented care-giving system which accounted, in part, for the crisis. Implicit was the assumption that the major problems could be solved by a heavy flow of federal dollars into the community. It was clear, however, that such a solution was two to three years in the offing, at least, since no mechanism for moving into the next phase of the planning or implementation process existed. Neither the state nor the local community could provide matching funds required for community mental health centers applications, and no community coordinating body existed with decision-making authority to develop a comprehensive strategy or action plan.

The project staff believed that this temporary vacuum on the community level could be turned into an opportunity for the professionals in existing institutions to improve the delivery of service systems through the training project. The project would be an opportunity for professionals to come together and begin to discover what they could do to implement the goals of community mental health in their own programs.

As might be expected from the above description, the professionals were showing typical symptoms of people in unclear and ambiguous situations --- feelings of anxiety, confusion and helplessness. Most of them knew that a study of mental health needs had been made, but they had no sense of involvement with it, and they felt isolated from the planning effort. In general, there was a sense that "someone up there" was making plans that would effect their growth and survival, and a concern that they ought to jump onto the community mental health bandwagon before it was too late. However, they did not understand what community mental health was all about, and how it differed from what they had been doing. Further, they did not know specifically what was being expected of them, who was setting these expectations, and what, if any, were their own choices or areas of decision-making.

On a behavioral level, their functioning was restricted. They stayed within the safe confines of their own territory -- they felt impotent to change things -- and the few who ventured forth in innovative directions, felt unsupported by their colleagues. It seemed clear that these attitudes of suspiciousness, mistrust and hopelessness would need to be changed before the professionals could begin to work together on common goals.

In regard to the impending implementation of the Community Mental Health Centers in the Cleveland community, we envisaged three areas of thrust for our project: (1) to provide the larger community with a sizeable professional group which had had an in-depth exposure to community mental health concepts

and ways of approaching problems; (2) to provide some training which would be relevant to professionals who might subsequently work on the staffs of the Centers; (3) to improve the existing network of agencies already delivering some elements of mental health care in the community.

THE EDUCATIONAL MODEL AND TRAINING DESIGN

In designing the educational curriculum, we made several assumptions which determined the content and teaching methods. The first of these was that community mental health could best be understood by regarding it as a system which overlapped with and was related to other community systems, including formal and informal social and political structures. Thus, the 3 courses of 10 weeks each on community mental health, new treatment strategies and consultation, were each presented from a systems point of view. (For details on this curriculum, the reader is referred to the Appendix).

Our second assumption was that the working mental health professional was far more capable of creative problem-solving and innovation than the system usually allowed. If he did not behave as a creative problem-solver, this was due, in large part, to the surrounding system which rewards passive compliance rather than individual initiative. Thus, we wanted to involve the professionals in their own learning and to encourage an active, experience-based learning process.

Our third assumption was that the most appropriate and least known change model relevant to the goals of community mental health was the human factors or sociocentric model. This model differs in many important respects from the bureaucratic model with which we are all familiar. The human factors model, as the name implies, emphasizes the person factors rather than the structural elements in changing organizations and systems.

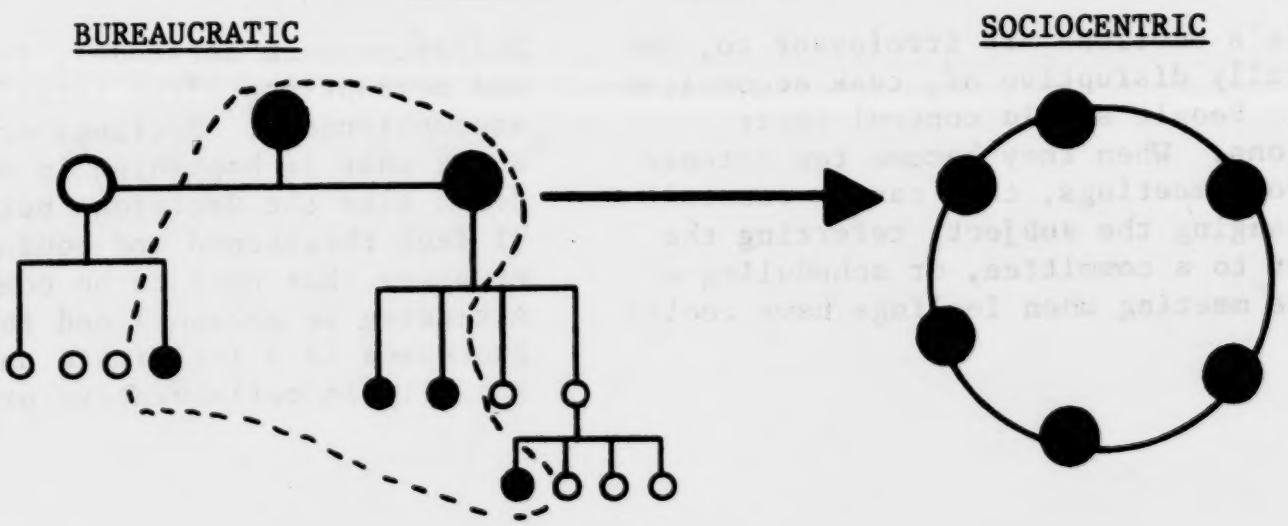
Although the sociocentric or human factors model of change is difficult to describe simply, some perspective can be gained by contrasting it with the more familiar bureaucratic model as outlined below:

BUREAUCRATIC MODEL	SOCIOCENTRIC MODEL
Organizational Structure and Change	
The basic building blocks of a system are the elements, e.g. units, departments, institutions.	The basic building blocks of a system are groups of people or teams.
Goal Setting and Decision Making	
It is only the planners, experts or administrators who have the broad perspective and necessary expertise to make informed decisions. Decision making is located in the role or position that one occupies in the hierarchial structure.	People support what they help to create. People affected by change must be participants and develop a sense of ownership in the planning and conduct of change. Decision making is a shared responsibility, and is located where the sources of problem solving information are, rather than in role or position.
Competition and Collaboration	
Competition is controlled and collaboration achieved by rewarding compliance to the plan by money and/or prestige. The exercise of power brings about change in people and systems.	Collaboration is possible when there is mutual trust and confidence. Win-lose competition can be minimized through a process of finding common goals. Groups and individuals are capable of managing their affairs against goals. Controls are interim measures.
Communication	
Communication is downward or lateral in the hierarchy. People on the lower level are expected to do what they are told, and will do so if the orders are clear and explicit.	Two-way communication laterally and horizontally, among and between all levels is necessary so that all the relevant information required to solve the problem can be brought up and considered.
Feelings and Attitudes	
People's emotions are irrelevant to, and generally disruptive of, task accomplishment. People should control their emotions. When they become too intense in group meetings, they can be controlled by changing the subject, referring the matter to a committee, or scheduling a future meeting when feelings have cooled off.	Differences in attitudes, feelings, values and perceptions often interfere with task accomplishment. Feelings are relevant data about what is happening in a group. "I don't like the decisions being made here" or "I feel threatened and confused", are messages that need to be communicated. Attending to personal and interpersonal processes is a legitimate and necessary activity in collaborative problem-solving.

In the bureaucratic model, the basic units of change are the structural units. System changes are accomplished by a series of directives from the top, passing down through the various levels. For example, in community mental health, a "master plan" is formulated on a national, state or local level, by a body of planners or experts, and is carried out by a series of marching orders to the members of the system. Compliance or cooperation with the plan is induced by appeal to motives of power, expansion and control or by subtle or covert threats of withdrawal of funds.

In the sociocentric model, the basic units of change are groups and the people in them. Persons from the organization or system are brought together into a temporary problem-solving group to formulate a tentative change plan. They are selected on the basis of some particular area of competence or interest they have in relation to the task. Leadership, responsibility, and authority are shared or rotated in relation to the task being performed at a particular moment in time. It is a team approach to problem-solving and requires openness, trust, and clear communication, including the expression of attitudes and feelings, so that all relevant data can be shared. The tentative plan made by this first group is the beginning phase of the planned change process, which then involves feedback, participation and collaboration between all components of the system.

The diagram below is a schematic representation of the way in which change is brought about: individuals from various levels within the hierarchy join to form a sociocentric problem-solving team.



This model views organizations as systems and considers relationships and inter-connections between the individual, the tasks, the goals, and the total environment. It is designed to deal with social and organizational problems of contemporary life which are complex, dynamic and rapidly changing.

While this model has been widely used in changing large systems, such as industrial organizations and schools, it had not heretofore been used as a model in training mental health professionals. It seemed a particularly appropriate and relevant one for several reasons. Community mental health is a complex problem, involving and affecting many systems, and in turn, is affected by them. The human factors model tends to develop the kind of working relationships necessary to achieve better coordination of existing resources and the integration of new community mental health centers into the total delivery of service system. Further, it recognizes the needs of professionals whose motivations to work include competency, self-esteem, self-realization and peer recognition as well as the hygiene needs of adequate remuneration. It also builds on the humanistically oriented, growth-producing model of change, to which most mental health professionals are committed in their work with individuals.

The training project was designed as an experimental laboratory for developing interdisciplinary and interprofessional working relationships and for training in change agent skills. In addition to bringing new information about concepts and practices in community mental health, we wanted to provide our participants with training and skills in the process of change. In terms of teaching methods, we believed that people best acquire new concepts and understand their applications when they can draw on their own experiences and be involved as active participants in their own learning.

<u>How did we integrate this learning of content and process into the curriculum itself?</u>

We used our own group process as a laboratory from which we could learn about the nature of change, and about strategies for coping with and creating change. We regarded the individuals who participated in the project as representatives of their home agencies, and we conceived of the project as a "temporary system" within the larger on-going system of mental health care in our community. We knew that this "temporary system" would exhibit all of the problems of the larger system -- poor communication, competition, uncoordinated efforts and a lack of awareness of what the participants were doing and how they were doing it. We also anticipated that in the nine months of the program we would be coming together as a group of relative strangers, only distantly related to each other, and that we would go through a process of group formation. That is, all those things would happen which <u>do</u> happen when a group of people come together around some common task -- which in our case, we hoped, was the creation of a more effective service system among the mental health care-givers of our community. We would test each other out to see who shared common goals or styles of working, whom we could trust, with whom we could share ideas -- in a word, we would discover with whom we could "do business." And we would be responding in this situation not only as "professionals" but also as people -- we would be put off by some of our fellow workers, turned on by others. Thus, we attempted to teach about change and barriers to change by taking a look at the factors which operated as the staff and the participants came together over the 180-hour, 9-month training period. Four two-day workshops were devoted to an intensive study of the training group as a microcosm of mental health change problems and to learning about change strategies, including the art of consultation. However, we paid attention to group process and change throughout the curriculum.

We did this in a number of ways. <u>First</u>, in order to encourage active participation in their own learning, the original curriculum was presented as a tentative one, subject to modification and change. We made it clear, both at the beginning of each year, and throughout the course, that the project was the property of the

participants and that the function of the staff was to facilitate their learning and changing.

Second, we focussed on "here and now" application of concepts presented during the lectures. During the discussion periods we asked the following types of questions: "How does what I've heard relate to me, my agency, to the community or to what is happening in this training group? What are the kinds of changes I see as being needed? What do I want to do, and what can I do to influence others to bring about change?"

Third, we attempted to create a climate of trust, openness and peer-colleague relationship. The staff was loose, informal and non-authoritative with each other and with the participants. We worked as a team in the development of the project, and shared our decision-making process with the group, as well as our feelings and disagreements.

Fourth, we used experience-based learning whenever possible.

The overview of the curriculum which follows illustrates the application of the above guidelines and the modifications in the second year which developed out of the feedback from the first year participants. (The interweaving of process and content is further illustrated in the detailed description of the curriculum in PART TWO.)

COURSE I - Community Mental Health

Particularly helpful in getting a sense of where the community of Cleveland was "now", were first hand reports of the planning efforts obtained from those directly involved in their development, for example, the Chairman and Executive Secretary of the Comprehensive Mental Health Planning Committee, and later, several members of the newly appointed County Community Mental Health and Retardation Board. The "experts" who came in from the outside to discuss delivery of service models gave some idea of the range of possible solutions to these problems, as well as some insights into the problems and frustrations of implementation. They also stressed the complex problems engendered in the integration of new mental health programs into

already existing community systems, and the identity crisis experienced by professionals in creating new roles for themselves, particularly in relating to paraprofessionals. All of the speakers, in one way or another, gave out a similar message: "Community mental health is a new business for all of us. We attempt to solve some problems, and in the process, discover new ones. As we go about making change, we must be open to revising our hypotheses and assumptions, developing new solutions and testing these out."

This course was modified during the second year, based on the feedback from the first year participants. At the final workshop of the first year, the participants still felt relatively unfamiliar with how community residents perceived their problem, what kind of help they saw as being needed, and what if anything they wanted from the professionals. They were also impressed with the fact that we had been talking about meeting "unmet needs" in the inner city, yet very few had left their offices and gone into the "turf" for the last 10 years or more. Thus, during the second year, a considerable portion of the course in community mental health was devoted to field studies of three inner city communities, each of them a "high-risk" community in rapid transition.

In studying these communities, the participants used hard data sources, such as information from census tracts and surveys. However, some of the time was spent in the communities getting "soft data" -- talking with people in bars, in super markets, community centers, housing projects, and in interviewing personnel in social agencies and in the schools as well as local politicians and clergymen. A few of the participants during the second year who were residents of these communities volunteered to serve as guides or as contact persons for us. This helped immeasurably in paving the way and giving us the support we needed to explore the unfamiliar.

COURSE II - New Treatment Strategies

In the first year of the program, new methods of treatment were presented, such as family therapy, crisis intervention, and group methods in which use was made of

the resources within the group itself. The didactic presentations were followed by demonstrations and practicum exercises in which everyone participated, either as "therapist" or "patient." The demonstrations by the staff were critiqued by each other and by the audience, and we used this as a demonstration of peer-group consultation, as an in-service training method and as a model for supervision.

The participants found this experience useful as an introduction to these new methods, but felt they needed further and more intensive exposure, before they would be comfortable in using them in their own work. This course was modified during the second year. The weekly 3-hour sessions were devoted to new types of delivery of service models, and 4 intensive workshops were offered to learn about family therapy as practiced by Virginia Satir, former Director of Amily Training at Mental Research Institute of Palo Alto, California; and crisis intervention as practiced by Carl Whitaker, Professor Psychiatry, University of Wisconsin School of Medicine. These workshops were open to project participants, the staff members of the participating agencies and graduate students. Among the 98 persons who attended, about 25% were project participants.

COURSE III - Consultation Methods and Change

During both years, process consultation, served as the training model. The most familiar model in mental health has been the "purchase" model in which the buyer brings in an outside expert to provide needed information or service. A related model is the "doctor-patient" model in which the outside consultant is brought in to "look them over", much as a patient goes to his physician for an annual check-up. The consultants are supposed to diagnose the system and prescribe a program of needed change. Process consultation, in contrast, focuses on joint diagnosis and the teaching of diagnostic and problem-solving skills to the client or client system. One of the key assumptions underlying the process-consultation model is that the client must learn to see the problem for himself and be actively involved in the diagnostic and problem-solving phase. The process consultant need not be an expert or an information giver in solving

the problem that is diagnosed; he needs to be an expert in how to diagnose and particularly in how to develop a helping relationship.

During both years, the change projects that had been developing among the participants or within their agencies were used as a basis for practicum exercises in consultation.

THE PARTICIPANTS:

WHO THEY WERE -- HOW THEY WERE RECRUITED

Since we were a demonstration project, we did not attempt to involve all of the mental health organizations. Instead, we aimed for a sample that would represent the gamut of mental health organizations that are typical of urban communities, for example, in-patient and out-patient services on the child and adult level, private social service agencies, plus those publicly funded human service institutions reaching large numbers of disadvantaged such as the County Welfare Department, the City Schools and the Economic Opportunity Councils.

Since the agency was our primary target of change, we needed to recruit a "critical mass" of individuals -- critical not only in numbers but in their power to bring about change. Thus, an attempt was made to involve several professionals from a single organization, preferably those who had policy or decision-making responsibilities, such as those with administrative, training of supervisory functions. Further, to maximize the possibility of impact, we tended to select agencies and individuals whom we saw as progressive and open to new ideas and to change. In total, 93 participants from 28 agencies were selected for the training project.

During the first year, 34 participants were recruited from 12 agencies -- 6 were directors from these agencies. In terms of professional roles, the group consisted of 4 psychologists, 5 psychiatrists, 18 social workers, 2 clergymen, 3 nurses, a hospital personnel director and an occupational therapist.

The second year, the group was larger in size, numbering 59 participants from 21 agencies. Five of these agencies had participated the previous year.

This group was more heterogeneous with respect to background and experience in mental health. With regard to professional affiliations, there were 12 psychologists, 5 psychiatrists, 23 social workers, 6 nurses, 2 chaplains from State hospitals, 2 lawyers (engaged in a pilot study at one of the State hospitals serving the legal needs of patients) and 9 who were serving in administrative positions in mental health or related agencies, but did not hold professional degrees.

OUTCOME

The dream or vision entertained by the staff of this project was the hope that those who attended the training project would become catalysts for change within their own institutions and within the larger community. Further, we hoped that this would result in a more effective service delivery network and greater efficiency in reaching the large population in need of service.

In retrospect, the project can be seen to have had three major sorts of impact: impact on individuals; impact on agencies; and, impact on relationships between agencies. Of course, the three sorts of changes cannot be separated one from the other, nor can we attribute all the changes that occurred during the period the project was in operation to its activities. In many cases, however, the observed changes would not have taken place without the existence of the project, and in a number of cases, the project served as a definitive facilitator to individuals or processes which already were in being.

The extent to which the project succeeded in producing or contributing to the hoped-for changes was assessed in two ways:

1. Research instruments: "Before" and "after" comparisons were made on such variables as: attitudes about community mental health, as measured by the Baker-Schulberg Ideology Scales; perception of other agencies; perception of critical problem areas.

2. Follow-up questionnaires and interviews: In keeping with our goal of producing behavioral change within and between agencies, our major evaluation was based on an appraisal of its value to the consumer, namely the participants and their agencies, and on an appraisal of the actual changes that had been effected by them in their "back home" organizations, which they may have attributed in whole or in part to the influence of the program. Each participant was asked to fill out a questionnaire shortly after completing the project (see Appendix for a copy of this instrument). Further, each participant was interviewed by one or more of the project staff approximately 9 to 18 months after the training project was completed. In a few cases we re-interviewed first year project participants after an 18-month interval.

In this section we will summarize the results obtained through these types of assessments.

Measurement of Impact on Participants as Assessed by Research Instruments

During both years of the training project, research instruments were administered to the participants before the training started and again immediately after the training project was completed. In this way, objective measures of attitudes toward community mental health, perceptions of problem areas encountered in community mental health, and perceptions of the relevance of local agencies in community mental health could be obtained. Complete "before" and "after" data were obtained on 27 participants the first year and on 29 participants the second year. Since complete "before" and "after" data was not available from many participants, there remains the question as to whether the results obtained from those that did complete the instruments are representative of those that did not.

Four short tests were administered both "before" and "after" the project. A version of the semantic differential developed by Schulberg and Baker was used to analyze reactions to the concept "community mental health."[1]. A second instrument developed by Schulberg and Baker[2]. was used to measure changes in the acceptance level of community mental health ideology over time; this instrument contains 5 subscales, each related to a separate aspect of community mental health. These aspects are "population focus", "primary prevention", "social treatment goals", "comprehensive continuity of care", and "total community involvement." A third instrument was developed by the project staff to assess attitudes about local community mental health problem areas. A list of 22 problem areas was presented, and the participants were asked to check the 5 areas they considered to be "most important" to community mental health in the Cleveland area. The participants were free to add any problem areas not listed. The fourth instrument dealt with changes in perceptions of the participating agencies seen as "most" and "least" directly involved with community mental health. Each year the participants were given a list of the participating agencies <u>for that year</u> and were asked -- both at the beginning of the year and at the close -- to select three agencies <u>most</u> involved in community mental health and three agencies <u>least</u> involved. The results obtained from the two years of the project were quite different from each other in some respects.

The semantic differential showed in both years no change in the degree of favorableness with which the participants viewed the concept of community mental health (Evaluation factor). The participants from both years saw the concept of community mental health to be more potent following the project than they had at the start, but this shift was of borderline statistical significance for both years (Potency factor).

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1. Schulberg, H.C., and Baker, F., The Meaning of Community Mental Health, June, 1967; mimeographed, Harvard Medical School, Cambridge, Mass.

2. Baker, F., and Schulberg, H.C., Community Mental Health Journal, 1967, 3 (3), 216-225

In the first year, there was a significant change in the direction of perceiving the concept "community mental health" as connoting an increase in positive activity (Activity factor). The second year showed a change in the same direction, but this was not statistically significant.

The Baker-Schulberg Community Mental Health Ideology Scale, which tests attitudes in the five areas mentioned above, also showed several differences between the two years. (A full discussion of the results in the five areas will be found in the Appendix). If one combines all five categories to obtain a total score, for the first year there is a significant "before" to "after" total change in attitude in the direction of a greater overall acceptance of the concepts of community mental health ($p = .005$ level, summing all category scores). Using the same total scores for the second year, the difference in the "before" to "after" scores is not significant. An analysis of co-variance using the total scores indicates that the difference in results between the two years of the project can be attributed to differences in "treatment". One possible explanation for the rather inconsistent results using this instrument is that the second year participants had high initial scores as compared to the large sample used by Baker-Schulberg to standardize their instrument. It is thus possible that our second year participants were so favorable to community mental health ideology at the start that it would have been difficult to increase their "favorableness." Evidence seems to suggest that this might be the case.

We used a third instrument to assess the effect of the project on participants' perceptions of the relative importance of certain problems in community mental health in the Cleveland area. Participants were asked to rank the five "most important" problems in order of importance. Some of the "before" to "after" changes are of considerable interest. First, one of the aims of the project had been to stress the idea that, through increased inter-agency collaboration, much could be accomplished with the resources at hand, i.e. without additional money or manpower. During the "after" assessment, "manpower shortage" dropped from first to sixth place for the

first year group, and from tie for fifth place to tie for eleventh place in the second year group. "Inadequate facilities" dropped from sixth place to a tie for twelfth place for the first year group, and from second place to a tie for fifth place in the second year group. (Other results of this instrument are reported in the Appendix).

We used a fourth instrument to assess the participants' perceptions of the agencies in the program. They were asked "before" and "after" to select, from among the agencies participating in their year, the 3 they felt most directly involved with community mental health, and the 3 they felt were least directly involved. As the participants got to know each other's activities more directly and closely, they came to appreciate the community mental health services rendered by agencies not traditionally considered as mental health facilities. For example, a community center which was not well-known shifted from being seen as tied for fifth place on "most directly involved" and from fourth place on "least directly involved" to second place on "most directly involved" and tied for tenth place on "least directly involved" by the end of the year. The most striking change in perception regarding an agency occurred during the second year. This agency was a multi-purpose service center in an area of rapid transition supported by the local Council on Economic Opportunity. It rose from being tied for twelfth place on "most directly relevant" before the project, to second place by the end of the project. On the whole, the staff has felt that the changes in attitude reflected by the responses to this instrument, have reflected more realistic perceptions on the part of the participants regarding the relative actual involvement of the various participating agencies with community mental health.

To summarize our impressions of the individual changes in attitudes, beliefs, and knowledge about community mental health based on the rating scales, and, reinforced by some of the interview material, there was an increased acceptance of the

goals of community mental health, an expanded definition of the field, and a greater sense of the responsibility of professionals and/or agencies to move in this direction. As one participant remarked: "You destroyed a basic myth I held and replaced it with a sense of reality. When I came into the program, I thought that everyone but me knew what each other was doing, and that there was some comprehensive mental health system operating. I realized that we were all isolated from each other; that our services were fragmented and we were 20 years behind the times in our treatment methods. Each of us could do something to improve the care-giving system by changing what we were doing or by linking up with others."

Measurement of Impact on Individuals and Agencies Based on Follow-up Questionnaires and Interviews:

The changes effected, directly or indirectly, by the project on the delivery of mental health services in the Cleveland area are summarized in five charts and discussed in the text.

Chart I - is an overall summary of the impact of the project on its participating agencies; the other 4 charts are derived from this one, each of them pointing up a particular aspect of the results of the project.

Chart II - lists the agencies on which the project had no apparent impact.

Chart III - lists those agencies whose participants reported changes in themselves deriving from the program, but who did not report changes in the policy or program of their agency.

Chart IV - lists the agencies in which the project influenced intra-agency activity or inter-agency activity or both.

Chart V - spells out the areas of change in the 15 agencies reporting impact on their activities due to the project. The judgements about impact were made by the three project directors, and were based on our evaluation of the relevance of the actual changes to the goals of community mental health.

CHART I - This chart gives a general overview of the project and its impact, indicating (a) the number of participants from each agency each year and how many of them held administrative positions; (b) the nature of the changes which occurred; (c) the extent of impact on the agency or individuals within it; and (d) membership in the Mental Health Exchange, a presently on-going group which grew out of the steering committee for the Administrators' Conferences held during the second year of the project.

Inspection of this chart shows that the training project had impact not only on the attitudes of individuals but in many cases had a substantial impact on the programs and policies of the participating agencies, including many developments of collaboration between agencies. More agencies from the first year evidenced major changes than did agencies from the second year. We would like to think that this is an artifact of our data-collection method, namely, the timing of the follow-up interviews. It takes time for changes to take place and our second year participants had not had as much time to change, by the time of writing, as had the first year people. In our re-interviews with the first year group, 18 months later, we frequently picked up the "sleeper effect," a common phenomenon in studies of psychotherapy and community change efforts. One member of the second year group applied for and received a grant for the training of local volunteers to help with patients following discharge from one of the State hospitals. Although this individual attributes the impetus to develop the grant application to the project, the full extent of the role of the project in this matter are not yet evident since it is not yet in operation.

One of the State hospitals sent a sizeable contingent to the second year, but the project showed little evidence of substantial impact on their system. Several of those interviewed from this hospital believed, however, that the pay-off would occur in the near future as the hospital moves into high hear in their community-oriented efforts.

C H A R T I

SUMMARY OF IMPACT OF TRAINING PROJECT ON INDIVIDUALS AND AGENCIES

NAME OF AGENCY	TOTAL PARTICIPANTS		ADMINISTRATORS		NATURE OF CHANGE			EXTENT OF IMPACT			MENTAL HEALTH EXCHANGE MEMBERS
	Year I	Year II	Year I	Year II	No change	Change only in individuals	Intra agency change	Inter agency change	Major impact	Minor impact	No impact	
1. Beechbrook Children's Home	3	3	1	0			X	X	X			X
2. Booth Memorial Hospital	0	5	0	2		X				X		
3. Cleveland Board of Education	0	3	0	0			X			X		
4. Cleveland Center on Alcoholism	1	0	0	0				X		X		
5. Cleveland Guidance Center	2	0	2	0				X		X		X
6. Cleveland Mental Health Assn.	1	0	1	0	X						X	
7. Cleveland Psychiatric Institute	0	8	0	0		X				X		
8. Cleveland State Hospital	0	12	0	2			X			X		X
9. Community Information Service	0	1	0	0		X				X		
10. Centra Opportunity Center (OEO)	0	1	0	0	X						X	
11. Cuyahoga County Welfare Dept.	4	3	2	0			X	X	X			X
12. Fairhill Psychiatric Hospital	11	6	7	0			X	X	X			
13. Family Service Association	1	2	0	2			X		X			
14. Glenville Opportunity Center (OEO)	0	1	0	1				X		X		
15. Hough-Norwood Family Health Care Ctr.	0	1	0	1			X	X	X			X
16. Jewish Children's Bureau	0	1	0	0		X				X		
17. Jewish Family Service Association	1	0	1	0				X		X		
18. Legal Aid Society	0	2	0	0	X						X	
19. Lutheran Children's Aid Society	0	1	0	0			X	X	X	X		
20. Marymount Hospital	4	0	0	0			X			X		X
21. Mental Development Center	1	0	0	0		X				X		
22. Mt. Pleasant Service Center	3	1	1	0			X	X	X			X
23. Riverview Community Center	0	1	0	1	X						X	
24. St. Luke's Hospital	0	3	0	1		X				X		
25. Traveler's Aid Society	0	1	0	0	X						X	
26. Visiting Nurse Association	0	1	0	0	X						X	
27. West Side Opportunity Center	0	2	0	1		X				X		
28. Youth Services	2	0	0	0			X			X		

CHART II - This chart lists our "failures", that is, those agencies in which our training effort had no apparent impact, either on individuals or on agencies. Many of these individuals attended irregularly or failed to complete the course. In most cases the pressures of agency business or shortage of agency staff prevented them from becoming regular members of the group. In one, or possibly two cases, we have reason to believe that the participants felt negatively either about the project or the staff. In one case, a participant, who was a lawyer, became increasingly frustrated and disgusted with the mental health professional viewpoint. He was strongly committed to an advocacy model and to immediate action, neither of which he saw being done by the mental health professionals. He dropped out of the project and subsequently developed an innovative legal service for State Hospital patients. Although the project had no influence on him, we do feel that he had a valuable influence on others in the project through his energetic and outspoken view concerning the need for legal and political action in the mental health field.

CHART III - This chart shows the agencies within which some individuals reported the project to have had personal impact but who were not able to influence their agencies, either in terms of new program development or in terms of new roles for themselves. These 13 persons (roughly 14% of the total training population) all noted some change in their own functioning on the job. Some felt more confident about contributing at staff meetings, more assertive about getting their ideas across to co-workers and better able to communicate clearly and openly with those in their organizational hierachies. Several felt that their overall job effectiveness had improved. One case worker reported that her increased sensitivity to her own feelings and the feelings of others enhanced her work with clients. Another who had become more sophisticated about the theory of organizational change was able to effect some inter-departmental changes that improved the handling of pediatric clients on an out-patient basis. One agency director told us he had become more aware of his difficulty in listening to, and working with, his board and said he was working on ways to improve his effectiveness with them.

CHART II

AGENCIES IN WHICH PROJECT HAD NO APPARENT IMPACT ON INDIVIDUALS OR ON THE AGENCY.

NAME OF AGENCY	NUMBER OF PARTICIPANTS YEAR I	YEAR II
Cleveland Mental Health Association*	1	0
Central Opportunity Center (CEO)	0	1
Legal Aid Society	0	2
Riverview Community Center	0	1
Travelers Aid Society	0	1
Visiting Nurse Association	0	1

Total agencies: 6

Total persons: 7

* The Director of this agency participated in the project and the following fall became Director of the Lutheran Children's Aid Society. See Chart IV for impact on this participant; there was no impact on this organization.

CHART III

PROJECT IMPACT ON INDIVIDUALS WITHIN AGENCIES BUT NOT ON AGENCIES

NAME OF AGENCY	NUMBER OF PARTICIPANTS YEAR I	NUMBER OF PARTICIPANTS YEAR II	NUMBER OF PARTICIPANTS REPORTING CHANGE YEAR II
Booth Memorial Hospital	0	5	3
Cleveland Psychiatric Institute	0	8	6
Community Information Service (Cleveland Welfare Federation)	0	1	1
Jewish Children's Bureau	0	1	1
St. Luke's Hospital	0	3	1
West Side Opportunity Center (OEO)	0	2	1
Total agencies:	6		
Total participants:	20		
Total of those reporting individual change:	13		
Total reporting no change:	7		

Several of the agencies listed on this chart were relatively large, with rather highly structured, bureaucratic organizations. Although some of the participants from these agencies wanted to move in new directions, they felt constrained by their systems. Two out of the thirteen have since have since moved to new positions which afford them greater autonomy and influence.

It will be noted that some, not all, of the individuals listed in Chart III reported attitudinal or behavioral changes. Thus if we note all individuals who report no change resulting from participation in the project, it can be seen that out of a total of 94 individuals, we consider that we had no impact on a total of 14 individuals, or roughly 16% of those involved in the project; likewise, we had minimal impact on 13 individuals, or 14% of the participants. Taken together, these figures mean that we had small impact or no impact on about 1/3 of our participants. Translated into number of agencies, these figures mean that we had no impact on 6 agencies or 21% of the agencies participating, and minimal impact (via intra-personal effects on personnel) on an additional 6 agencies, making a total of 12 agencies or 40% of participating agencies on which we had small or no impact. It is perhaps significant that all of these minimal-impact agencies participated only in the second year of the project, with the exception of the Cleveland Mental Health Association, on whose single participant we had considerable impact as he moved into a different setting. We shall discuss this contrast between the first year and the second year at some length in our Evaluation Section.

CHART IV - This chart lists the 15 agencies which sent a total of 65 participants, on which the program exerted a significant impact on intra-agency activity or on inter-agency activity or both. This chart also indicates the source of the core group of the Mental Health Exchange, which has now expanded to include individuals who did not participate at all in the program during its first two years. Examples of intra-agency changes include: one agency developing an across-the-board habit of examining its modes of functioning which recently resulted in an off-site week-end workshop for all members of its staff to work out plans for future developments; at least 2 agencies have introduced some of the staff training methods

introduced in the project into their staff development programs; several agencies have been encouraged to develop specialized programs within their agencies; for example, one agency developed an adolescent drop-in center as a result of encouragement for innovation received through the project.

The development of inter-agency linkages may have been one of the most significant results of the project. Such linkages resulted either in the development of new mental health services being delivered, in the creation of new programs, or in an increased ease of referral and consultation between agencies. Perhaps the most striking linkage to emerge from the project was the association of Mt. Pleasant Community Service Center with Beechbrook Children's Home. These two agencies have joined hands to make contracts which will lead to the formation of a federally-funded Community Mental Health Center -- one of the few in the country which will be community-based and which will carry a primary emphasis on children and hence on truly preventive services. This coalition has already been funded by the local County Community Mental Health and Retardation Board for two years of planning and program development; in addition, these two agencies have banded together in the development of a summer program (about to commence its second operational year) for disturbed inner city school children.

Other linkages indicated in Chart IV include:

1) a project in which the Center on Alcoholism provides training for Mt. Pleasant workers in running groups locally for alcoholics;
2) projects between the Cleveland Guidance Center and two school systems in the city, wherein the Guidance Center provides group work and individual services as well as work with parent groups for children from the school systems in the two areas;
3) a significant facilitation of referrals between the County Welfare Department and Beechbrook -- which now accepts emergency placement of problem children with a focus on attempting to resolve the problem with involvement of the family, and, hopefully, avoidance of permanent institutional placement of the child;

4) the development of a crisis intervention team from Family and Children's Services of the County Welfare Department which serves an inner city Welfare Office for the purpose of early detection and crisis intervention;
5) a contract between the County Welfare Department and the Guidance Center wherein 20 children are constantly on the Guidance Center rolls from the Welfare Department, 15 of whom are paid for by the Welfare Department, 5 funded by the Guidance Center; these referrals are now accepted by the Guidance Center without the customary extended pre-treatment studies;
6) Fairhill Psychiatric Hospital (a local state receiving hospital) formed an agreement with the Glenville OEO center in the inner city -- at first, to have a social service representative from Fairhill spend time each week in the OEO center following up discharged patients; this subsequently developed into a program wherein indigenous workers from the Glenville area visit the hospital weekly to meet with patients from their area and plan their post-discharge follow-up, a significant tertiary prevention measure, since the patients now have local acquaintances available to them, and need not make the long trip to the hospital to receive some post-hospital care;
7) the County Welfare Department now uses the Mt. Pleasant Service Center as a training agency for some of its Community Aides.

There are other examples of such linkages. We feel that the establishment of such a host of them and their continuance and further development over time was undoubtedly due to the informal and in-depth types of contact made at the project between representatives of various agencies and various disciplines. Some of these linkages might have occurred without the existence of the project, given the planning and funding authority of the Cuyahoga County Community Mental Health and Retardation Board, which was established at the time the training project was entering its second year. Some of them, we are convinced, would not have occurred without the project as a convener of agencies previously unknown to each other.

C H A R T IV

FIFTEEN AGENCIES IN WHICH PROJECT INFLUENCED INTRA-AGENCY ACTIVITY OR INTER-AGENCY ACTIVITY OR BOTH

NAME OF AGENCY	NUMBER OF PARTICIPANTS YEAR I	YEAR II	INTRA-AGENCY CHANGE	INTER-AGENCY CHANGE	MENTAL HEALTH EXCHANGE MEMBERS
1. Beechbrook Children's Home	3	3	**	**	+
2. Cleveland Board of Education		3	*		
3. Cleveland Center on Alcoholism	1	0		*	
4. Cleveland Guidance Center	2	0		**	+
5. Cleveland State Hospital	0	12	*		+
6. County Welfare Department	5	3	*	**	+
7. Fairhill Psychiatric Hospital	11	6	*	**	
8. Family Service Association	1	2	*		
9. Glenville Opportunity Center (OEO)	0	1		*	
10. Hough-Norwood Family Health Care Ctr.	0	1	*	*	+
11. Jewish Family Service Association	1	0	*		
12. Lutheran Children's Aid Society	0	1	*	*	
13. Marymount Hospital	4	0	*		+
14. Mt. Pleasant Service Center	3	1	**	**	+
15. Youth Services	2	0	*		

Total agencies: 15
Total participants: 65

* Indicates agency in which project facilitated some change.
** Indicates agency in which project facilitated major change.
\+ Indicates agency which at present continues to participate in the Mental Health Exchange among agency administrators which evolved from the project.

An important outgrowth of the project was the evolvement of an ongoing forum for administrators from the various mental health agencies who participated in the training project. The project staff called a series of four meetings during 1969-1970 for the directors of participating agencies, many of whom had little or no involvement in the Community Mental Health Training Project except as they heard about it through their staffs. A total of 50 attended these Administrators' Conferences. The Steering Committee for these conferences has continued and now calls itself "The Mental Health Exchange". This body continues to meet and has extended its membership to include other directors and program administrators. (Those agencies designated with a (+) in Chart IV are among those that participate in this ongoing forum). These meetings serve a number of unmet needs of the administrators themselves. The meetings are used to share information about funding sources, program ideas and political strategies and in some cases to use each other as consultants on administrative matters. These meetings also serve the function of providing a supportive colleague group for people who because of their administrative roles, frequently feel isolated and alone. Observing the interactions and communication styles of this group over time, the staff has been impressed with the present atmosphere of openness and trust.

CHART V - This chart delineates the areas in which "significant" or "very significant" changes occurred within the 15 agencies listed in Chart IV as having undergone changes as a result of the project. These changes were categorized in 6 areas, the first 5 of which are derived from the Baker-Schulberg categories, mentioned earlier in our discussion of research instruments. A rating of (0) indicated no change; (+) indicated some change and (++) indicated significant change. A rating of (0) does not mean that the agency is not working to achieve in this area, but only that the training project had no influence on its activities in this area.

C H A R T V

IMPACT ON AGENCIES IN SIX AREAS OF COMMUNITY MENTAL HEALTH

0 = no change + = some change ++ = significant change

Name of Agency	Population Focus	Preventive Strategies	New treatment Strategies	Continuity of Care	Increased Community Involvement	Improved Organizational Effectiveness	Totals
Beechbrook Children's Home	++	++	++	++	++	++	12+
Cleveland Board of Education	0	++	0	+	0	0	3+
Cleveland Center on Alcoholism	0	+	+	0	+	0	3+
Cleveland Guidance Center	0	+	+	+	+	0	4+
Cleveland State Hospital	0	0	+	0	+	+	3+
County Welfare Department	0	++	+	++	+	+	7+
Fairhill Psychiatric Hospital	0	+	++	++	+	+	7+
Family Service Association	+	+	+	+	+	++	7+
Glenville Opportunity Center	+	+	+	++	0	0	5+
Hough-Norwood Family Health Care Ctr.	++	++	++	+	++	++	11+
Jewish Family Service Assn.	+	0	+	0	0	0	2+
Lutheran Children's Aid Society	+	+	+	+	0	++	6+
Marymount Hospital	+	0	+	0	+	0	3+
Mt. Pleasant Service Center	0	++	+	++	+	++	8+
Youth Services	0	+	+	0	0	+	3+
TOTALS	9+	17+	17+	15+	12+	14+	

The categories of agency change listed are:

1) Shift to a population-centered approach, that is, the agencies were designing programs more closely related to the needs of the population they were supposed to be serving; they were evaluating program effectiveness in terms of meeting assessed needs.
2) Focussed on preventive strategies through consultation or education of community care-givers and educators.
3) Adopted new treatment strategies that extend coverage such as family therapy, group methods, crisis intervention services and new uses of sub-professional and non-professional manpower.
4) Improved the continuity of care through improved referral and follow-up services either in their own institutions or in the community.
5) Increased community involvement by involving consumers of services on the policy-making or advisory level; developing closer ties with formal and informal systems in the surrounding or larger community.
6) Improved the effectiveness of their own organizations by opening up communication channels between and within staff levels or by changing decision-making patterns to allow for more participation of staff in program development and policies of agency.

As shown in Chart V, the training project served to catalyze change in 15 of the 28 agencies participating, or in approximately 54% of the agencies.

We consider the outstanding "successes" to be those which accumulated an overall or total rating of 7 or above; 7, or 25% of the participating agencies received this rating. Again, of these 7 agencies only one, the Hough-Norwood Family Health Care Center, participated in the second year only. The areas which received most attention from our participating agencies were: preventive strategies and new treatment strategies (a total of 17 points each), continuity of care (15 points), and improved organizational effectiveness (14 points). Of the 7 agencies receiving the

higher ratings, 6 had participants in both years of the project; the 7th had only one participant who shared in the second year, but who was and is extremely active.

In summary, in terms of impact, the project had -- as measured by our research instruments -- considerable impact on individual perceptions of community mental health and increased investment of energies in this concept. As measured by the questionnaires and follow-up interviews, the project had a slight impact on 14% of our participants and on 6 agencies; we had no impact on 15% of our participants and on 6 agencies. The project had significant impact on 8 agencies or 29% of participating agencies and very significant impact on 7 agencies or 25% of them. Five agencies underwent very significant inter-agency changes; two agencies underwent very significant intra-agency changes. Seven agencies joined in the presently ongoing Mental Health Exchange. Four agencies underwent less significant inter-agency changes and six agencies underwent less significant intra-agency changes.

EVALUATION OF THE TRAINING PROJECT

In one sense the evaluation of the project has already been implied through the review of its outcome in the areas of: increased knowledge; changes in attitudes and behavior; and, resultant changes in intra- as well as inter-agency functioning. These results have been described, in part, in the above section on Outcome.

In this section on Evaluation, we wish to take a broader look at the underlying philosophy of the project and at the strategies and tactics which were employed to implement this basic philosophy. Evaluation will take the form of pointing out what we now see as the "advantages" of what we did, plus, some of the "difficulties encountered." Our purpose is not only to call attention to the positive aspects of such a project, but it is also to prepare those who would attempt such a project in the future -- and we hope there will be many -- for the barriers and resistances that they might well encounter, in the hope that they might be better prepared to deal with them than we were.

The "advantages" and "difficulties encountered" will be reviewed within the context of what we consider to be seven areas of particular emphasis in the project. These areas of emphasis involve either a fundamental educational philosophy or a major change strategy.

I. A stress throughout the project on the process of developing creative collaboration to do meaningful problem-solving.

ADVANTAGES	DIFFICULTIES ENCOUNTERED
Process has wide applicability to many mental health work situations.	Violates traditional view that solution to all mental health problems lies in more resources (money, manpower, bricks, mortar).
Gives individuals increased sense of own power to make a difference.	Violates view that all the power lies in the "boss" to make things better.
Through development of mutual concern and caring, reduces sense of aloneness and isolation.	Violates the view that planning for change comes from the top down.
Increased personal satisfaction through sense of support.	Goes against tradition of local competition for scarce resources.
Usual formal organizational changes seen as not required to get things done.	Suggests new skills, techniques, roles needed; suggests shift in self-concept and traditional status rewards which may be threatening to the individual.
	Difficult to see relevance of microcosm of project for macrocosm of "real world."

COMMENT: Given the great service demands on most mental health professionals, and given the lack of a tradition that supports careful evaluation of efforts, there is little motivation to do things differently or to see the advantages of collaboration even when changes are desired. Further, the skills and techniques of creative collaboration are not taught as part of the needed armamentarium of the mental health professional.

II. As part of developing creative collaboration, there is a heavy focus on the concern for inter-personal process.

ADVANTAGES	DIFFICULTIES ENCOUNTERED
Increased sensitization to processes having wide applicability for mental health professionals.	Violates expectation of content-only oriented traditional course.
Builds sense of community for individual, with much personal support.	Emphasis on inter-personal process seen as irrelevant.
Mutual caring and concern from colleagues encourages risk taking, "stretching" and therefore personal growth and development.	Too close to "psychotherapy"; provokes mental health professionals' "allergy" to self-examination within context of colleague work groups.
Closeness and informality reduces sense of isolation and increases fun of working together.	Lack of willingness to stick with process orientation to experience relevance.
Increases sense of personal power to bring about change.	Difficulty in describing process during recruiting phase prior to direct experience.
	High degree of motivation and tolerance for ambiguity needed on part of participants.
	Low initial obvious payoff.
	Lack of staff experience to make all inter-personal experiences educationally productive

COMMENT: There are several attitudes that must be changed before the initial resistances to taking seriously a close examination of inter-personal processes can be overcome. One is that "we've been doing it already, and we never have any problems;" another is the attitude that "important innovations come from the outside" -- usually via the pronouncements of an expert with the Word; finally, a failure to see the relevance of the processes encountered in the microcosm of the interactions during the training project for "back at work." But if these resistances can be worked through, the individual can experience the many advantages listed above, not the least of which are a sense of his own power to make a difference and an increased sense of joy in his work.

III. The selection of a broad spectrum of mental health professionals and members of related professions to participate in an informal and democratic learning atmosphere.

ADVANTAGES	DIFFICULTIES ENCOUNTERED
Opportunity to encounter other professionals as individuals without usual status-power differences intruding.	Problem for some professionals not to play traditional roles.
Opportunity to communicate openly without usual formal organizational barriers.	Informal exchange seen as "waste of time when we should be learning."
Opportunity to share informal information about work life and to learn about actual functioning of other agencies.	Needs of mental health administrators not the same as line workers.
	Lack of common background for both mental health and non-mental health, though related, professionals.

COMMENT: Time was carefully built into the project (as for example, long coffee breaks) to permit informal interaction on the part of the participants. There was much sharing of information, and "business" was often transacted. One important result of this activity was the fact that many long-held stereotypes about individuals, professional roles, and about agencies were modified. Another result was the building of a sense of community with important personal ties that could be made use of on the job.

The fact that mental health administrators often had different needs and different issues to discuss than the line workers led to the development of periodically held Administrators' Conferences during the second year of the project.

IV. Encouragement of participants to develop a sense of ownership in helping shape training program.

ADVANTAGES	DIFFICULTIES ENCOUNTERED
Serves as a model of participative management; mutual decision-making.	Violates traditional educational model where the all-knowing Expert gives the Word to the uninitiated.
Giving sense of power to have an impact on a complex system.	Lack of experience in participative decision-making.
Gives practical experience in collaborative planning where needs of participants are taken seriously and acted on.	Suspicion that staff has a "hidden agenda."

Gives participants awareness of own resources within the group.	Tendency to utilize a competitive, advocacy power model rather than a co-operative collaboration model to arrive at decisions.

COMMENT: Some participants find it difficult to understand and appreciate an experienced-based learning model when so much of the education in mental health has been with the Expert-oriented, passive learning process.

V. Emphasis in project upon the participants having direct exposure to "high risk" local communities and to more vocal representatives of these deprived communities.

ADVANTAGES	DIFFICULTIES ENCOUNTERED
Opportunities to learn first-hand about the dynamics of a "high-risk" community and its mental health needs.	Direct work in community not a new experience for some participants.
Opportunity to hear about perceptions of members of a deprived community regarding adequacy of mental health system.	Defensiveness on part of some participants as a result of "hard confrontation" by more vocal minority representatives.
Opportunity to dialogue with representatives from "high-risk" community to learn first hand of their needs.	Difficulty of working through "blaming and guilt" phase to develop collaborative relationship for mutual benefit.

COMMENT: Perhaps one of the most difficult issues the project staff had to deal with was the appropriate structuring of the "confrontation" between the more militantly vocal members of the deprived communities and the predominantly white, middle-class professionals, in order to move on to the next stage of mutual problem-solving. The staff learned the importance of devoting a sufficient amount of time for the working through of the "speech-making" phase without the polarization of the situation becoming a barrier to further working together.

VI. Staff team building process used as model for participants.

ADVANTAGES	DIFFICULTIES ENCOUNTERED
Increased awareness of importance of working through inter-personal issues that are reducing effective collaboration.	Participants disturbed by lack of "united front" on all issues on part of the staff.
Direct experience with "experts" who do not have all the answers.	Staff as perceived as "in conflict" or"not sure what they're doing."

Can observe a team with members having equal say in decision-making.

Can observe team within which professional role not linked to power status.

Violates expectations that the Expert has the answer (and that there is only one answer).

COMMENT: It was a fundamental belief on the part of the staff that we could not help the participants deal with their inter-personal issues unless we could successfully handle our own, even making use of an outside consultant when needed. Despite some serious disagreements, the staff had a fundamental common philosophy, plus a willingness to "hang in there" and work through the problems together. Another staff strength was an appreciation for each other's differences and unique backgrounds. We saw this as adding much richness to the project.

As suggested above, a stress was placed upon individual equality in the staff team. This point of view got expressed in such concrete ways as having equal salaries for Director and Associate Directors alike.

VII. Decision not to seek total mental health establishment support, but to work with individuals and agencies who seemed ready to innovate in area of community mental health.

ADVANTAGES

High probability of innovative changes taking place in individuals and agencies.

Reduces chance of co-optation by power structure of Establishment.

Advantages of project being seen as "neutral" and not promulgating a particular power structure point of view; project not part of inter-agency competitive struggle.

DIFFICULTIES ENCOUNTERED

Without active support by mental health Establishment, project seen by some as lacking "respectibility."

Lack of continuing funding support from Establishment at termination of Federal funds.

Time limitations of demonstration project meant not as many trained as is necessary to have impact on larger institutions.

Difficulty in providing continued support for innovations begun.

COMMENT: The project had to deal with the dilemma that those members of the mental health Establishment with the power to bring about changes would probably be the ones most resistant to innovations which would threaten the status quo. The decision was made to work around the Establishment as much as possible. But the price paid for this decision was the lack of total understanding of the philosophy of the project on the part of many -- we were called "mere conveners" by one key power figure -- and by the lack of continuing funding to do a more concentrated version of the project involving in-depth working with all relevant agencies in a "high-risk" area. However, in terms of the impact the project had on the mental health community, considering the fact that the time for the project was little more than is required for a single year-long graduate seminar, the decision regarding the Establishment was probably a wise one.

As one reviews the results of the project (See Outcome section above; also Appendix material on the details of the test instrument results), the differential impact between the first and the second year stands out. It looks as though the first year of the project had considerably more impact than the second. There are several possible explanations for this.

--The First Year Group was a Smaller Group. This meant that the staff had an easier time staying in touch with the first year participants and in getting a sense of "where the group was" psychologically. This also meant that, in the first year, the staff members were more effective as "trouble shooters," in sensing dissatisfactions and in encouraging participation from the more quiet members.

--The First Year Group Spent More Time Together as a Total Group. Because of the time spent in small teams studying three local "high risk" communities, the second year participants had less opportunity to work together as a total group, and therefore to profit from its heterogeneity. This circumstance also meant that the participants in the first year could get to know each other better and perhaps learn more from each other.

--The First Year Group Was More Carefully Selected. This group was more "hand picked" in the sense that the staff wanted the initial year of the project to be particularly successful; more time was spent on selection and in explaining the project to potential participants. During the second year, after the staff decided to open the project up to a wider spectrum of the community, a more lenient policy of "everybody welcome" was instituted. The heterogeneity of the participants of the second year was a mixed blessing. It made for livelier discussions, a better appreciation of the variety of services and persons in the mental health service system. On the other hand, the variation in interests and background made it difficult for the staff to program the total educational experience in ways that would be relevant and informative to everyone involved.

--The First Year Group Had a Less favorable and Accepting Attitude Initially Towards the Concepts and Values of Community Mental Health. If one looks at the initial attitudes of the first and second year group for those participants who remained in the project and filled out both "before" and "after" test instruments, the first year group -- particularly on the Baker-Schulberg measures of community mental health ideology -- had considerable lower average scores indicating less acceptance of commonly agreed upon community mental health ideology. In a sense, then, the second year participants who remained with the project had such a high initial acceptance of what the staff was trying to do, that it would have been almost impossible to show any "improvement" making use of the instruments at hand. One speculation about the possible reason for this more favorable attitude on the part of the second year group is simply that many of the community health concepts were becoming more current and more common knowledge during the year-long intervening period.

--The First Year Group Contained More Key Administrators. One possible reason for both greater behavioral and attitudinal change during the first year was the fact that the administrators who attended the project were in more powerful decision-making positions in their organizations. This meant that they were more able to

influence the activities of their agencies along lines congruent with community mental health ideology. It also may account for the more favorable initial attitudes on the part of the second year group towards community mental health concepts, since a powerful executive in a key position can strongly influence those with whom he works.

At the beginning of the Project our hope and dream had been to help create a collaborative mental health community which would make better use of existing resources in our city.

The demonstration Project is now over and we see that many creative, collaborative associations continue to flourish. There can be no doubt but what these associations enhace the delivery of mental health services in our community. We feel a sense of considerable success; and the painful struggles along the way are beginning to fade into the background. It is our further hope that others may benefit from this report of our experiences. Clearly, each community has its own particular problems and assets, and is at its own particular point of development. Thus, no cookbook program can help in fostering the development of a community's mental health resources.

We ourselves, however, come away from the Project with the conviction that our successes relate directly to our emphasis on the socio-centric model and our extensive use of experience-based learning.

We hope that this report of our experiences may encourage others to mold some of our work to fit their own problems and challenges. We wish you success.

Part Two

DETAILED DESCRIPTION OF CURRICULUM AND PROGRAM

COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT

CASE WESTERN RESERVE UNIVERSITY

CLEVELAND COLLEGE

FIRST YEAR: 1967-1968

STAFF

Elaine Kepner, Ph.D.	Director
Joseph H. Handlon, Ph.D.	Associate Director
Cynthia Harris, M.D.	Associate Director
Rose Stevenson	Secretary

ASSOCIATES

Arthur Blum, D.S.W.	Professor, School of Applied Social Sciences, CWRU
Steven Fink, Ph.D.	Assistant Professor, Organizational Behavior, School of Management, CWRU
Magdalena Miranda, M.S.W.	Instructor, School of Applied Social Sciences, CWRU
William Warner, Ph.D.	Associate, Department of Psychology, CWRU

GRADUATE STUDENTS

Frances Baker, M.A.	Department of Psychology, CWRU
Hans Daumer, B.A.	Organizational Behavior, School of Management, CWRU
Robert Gordon, B.A.	Organizational Behavior, School of Management, CWRU
David Phoenix, B.A.	School of Applied Social Sciences, CWRU

CASE WESTERN RESERVE UNIVERSITY

Cleveland College

COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT

First Year Of Project

1967 LIST OF PARTICIPANTS AND PARTICIPATING AGENCIES 1968

BEECHBROOK CHILDREN'S HOME - 3737 Lander Road 44124

Terry Chevers, MSW., Therapist
Paul Straub, MSW., Unit Supervisor
William Warner, Ph.D., Executive Director

CLEVELAND CENTER ON ALCOHOLISM - 2071 East 102nd Street 44106

Helen Spears, MSW., Case Work Supervisor

CLEVELAND GUIDANCE CENTER - 2525 East 22nd Street 44115

Clyde Harrison, MSW., Assistant Director
Gordon Loomis, M.D., Director

CLEVELAND MENTAL HEALTH ASSOCIATION - 1001 Huron Road 44113

D. Marshall Begley, Director

CUYAHOGA COUNTY WELFARE DEPARTMENT - 220 St. Clair Avenue NW 44113

Arthur R. Goldfarb, MSW., Director of Institutional Dept., Div. of Child Welfare
Marjorie Hall, MSW., Director, Staff Development Program
Jean Harris, MSW., Coordinator of Psychiatric Services
Steven Minter, MSW., Chief, Bureau of Resources

FAIRHILL PSYCHIATRIC HOSPITAL - 12200 Fairhill Road 44120

Jankiel Barg, M.D., Clinical Director
Barbara Ballard, RN., Admitting Nurse Coordinator
Marvin Gottlieb, M.D., Chief of Clinical Services
Leonard Haas, M.D., Chief, Out-Patient Services
Rev. John Herman, S.T.B., Chaplain
Josie Lindsay, RN., Nursing Service Director
Milton Matz, Ph.D., Psychological Services
Phyllis Peterson, MSW., Social Worker
Ruth Rosen, MSW., Director of Social Service
Anne Schaffner, Ph.D., Director of Psychological Services
Richard Schwartz, M.D., Chief of Male Services
Mildred Shelley, M.D., Director of Hospital Community Services Unit

PARTICIPANTS AND AGENCIES - 2 - 1967-1968

FAMILY SERVICE ASSOCIATION (West Office) 8409 Detroit Avenue 44102

Effie Warren, MSW., Case Worker

JEWISH FAMILY SERVICE ASSOCIATION - 2060 South Taylor Rd. 44118

Anne Schwartz, MSW., Director of Professional Services

MARYMOUNT HOSPITAL - 12300 McCracken Rd. 44125

Sister Edwardine Jerzy, RN., Psychiatric Supervisor of Nursing
Antonia Kurent, MSW., Director, Department of Social Work
Dale Leverett, M.A., Occupational Therapist
Thomas Nemeth, M.A., Personnel Director

MENTAL DEVELOPMENT CENTER - Case Western Reserve University 44106

Simon Miranda, M.A., Clinical Psychologist

MT. PLEASANT CENTER - 12714 Union Avenue 44105

James Spencer, MSW., Program Director, Community Services
Murtis Taylor, MSW., Director
Eleanor Warner, MSW., Urban Generalist

YOUTH SERVICES - 1001 Huron Road 44113

Mary Brumbach, MSW., Case Worker
Charles Vogt, MSW., Case Worker

COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT

Cleveland College, Case Western Reserve University

FIRST YEAR CURRICULUM 1967-68

COURSE I - COMMUNITY MENTAL HEALTH CONCEPTS

One two-day workshop and
nine weekly three-hour sessions.

COURSE II - NEW APPROACHES IN TREATMENT

One two-day workshop and
nine weekly three-hour sessions.

COURSE III - CONSULTATION: PROCESS AND METHODS

One initial two-day workshop
nine weekly three-hour sessions, and
final two-day workshop.

WORKSHOP I - COMMUNITY MENTAL HEALTH CONCEPTS

This course began with a two-day workshop to familiarize participants with the goals of the project, to give an overview of the curriculum and to obtain feedback concerning the relevance of the prepared curriculum to perceived needs for new information and skills.

FORMAT OF WORKSHOP I

1. Overview of mental health needs and problems in Cleveland.

   William Heston, Vice-President, Case Western Reserve University; Chairman, Comprehensive Mental Health Planning Committee, Region I, Welfare Federation of Cleveland.

2. Review of the Community Mental Health Training Project, with reference to the goals and policies of the Mental Health Centers Act and the National Institute of Mental Health.

   Elaine Kepner, Project Director.

3. Overview of curriculum.

   Joseph Handlon and Cynthia Harris, Associate Project Directors.

4. Small group discussions to:

   a. familiarize ourselves with each other, and the work of our agencies.

   b. share our expectations about this training program and our reactions to the proposed curriculum.

5. Summary session to pool feedback from small group discussions and to plan for integration of this information into the curriculum.

SUMMARY AND EVALUATION OF WORKSHOP I BY STAFF

Assessment of needs for new information in each of the content areas:

1. Community mental health. General lack of knowledge about the public health approach to community mental health, the actual needs and resources in Cleveland and the current status of mental health planning on the local level.

2. New treatment approaches. Unfamiliarity with new treatment strategies such as family and group therapy, crisis intervention and preventive programs which are community oriented; considerable interest in training and using indigenous non-professionals.

3. Consultation and organizational change. Little understanding of the consultee-centered model of consultation and of human factors approach to planned change.

Assessment of attitudes based on observations and inferences made by staff:

1. Feelings of powerlessness and hopelessness about change efforts.
2. Lack of knowledge about the purposes and functions of other agencies and professionals; and general guardedness in dealing with each other.
3. Strong tendency to see the problem as "out there" and capable of solution by "others."
4. Lack of perceived need for changes in agency programs and defensiveness about their agencies. A frequently heard phrase was "We've been doing community mental health for years now -- that's what our program is all about."

IMPLICATIONS FOR CURRICULUM

The following content areas were seen as needing to be stressed in the course on community mental health:

... Implications of the "Growth Model" and the "Illness Model."

... Community Mental Health; the social planning philosophy underlying the national, state and local plans; the various definitions of community mental health.

... Epidemiology; the findings in epidemiology that serve to shape the plans; the present and anticipated needs in the mental health field.

... Current mental health planning in Ohio Region I, including the recent Ohio legislation and the implementation means, e.g., the locus of decision-making.

policy planning, priority setting and funding problems; inter-relationship of city, county, state, and federal planning and implementation.

... Community mental health as a system and the process of planned change; how does a community go about reorganizing itself to change service patterns and delivery of service strategies? What are the problems in the implementation of change plans?

... A review of the new delivery of service models and programs already in operation.

... Manpower problems and the changing roles of professionals.

COURSE I

COMMUNITY MENTAL HEALTH

Weekly three-hour sessions

Session I: IMPLICATIONS OF THE "GROWTH MODEL" FOR COMMUNITY MENTAL HEALTH.

Guest speaker: Virginia Satir, MSW., former Director of the Family Training Project, Mental Research Institute, Palo Alto, California. Director of Residential Training, Esalen Institute. Author of "Conjoint Family Therapy."

Resource material:

Community Mental Health: Means or end? Harry R. Brickman, M.D., Reprint from Psychiatry Digest, June, 1967.

The Family as a Treatment Unit. Virginia Satir, MSW., Reprint from Sixth International Congress of Psychotherapy, London, 1964.

Session II: THE CLEVELAND SCENE: COMPREHENSIVE MENTAL HEALTH PLANNING IN OHIO REGION I, AND THE RELATIONSHIP BETWEEN THE CLEVELAND, STATE AND NATIONAL PROGRAMS.

Guest speaker: H. Bernard Smith, Executive Secretary, Comprehensive Mental Health Planning Committee, Cleveland Welfare Federation.

Resource material:

Fact Sheet: Community Mental Health and Retardation Act (AM. H.B. 648)

Map of Ohio Region I-Mental Health Catchment Areas; Research Department Cleveland Welfare Federation.

Interaction for Mental Health, A Summary of Recommendations. Cleveland Welfare Federation, Comprehensive Mental Health Planning Committee.

Session III: THE CLEVELAND SCENE AS REPRESENTED BY THE PARTICIPATING AGENCIES IN THIS PROJECT.

A representative from each agency reviewed his institution with particular reference to types of programs and populations being served and future goals and plans to extend coverage.

Session IV: EPIDEMIOLOGY AND THE PUBLIC HEALTH APPROACH: BASIC CONCEPTS AND MAJOR FINDINGS FROM EPIDEMIOLOGICAL STUDIES OF MENTAL DISORDERS. THE RELEVANCE OF THE EPIDEMIOLOGICAL METHOD FOR ETIOLOGY AND FOR PREVENTION.

Speaker: Joseph H. Handlon, Ph. D., Project Staff.

Resource material:

Summary Tables - by Joseph H. Handlon, Ph. D.

Facts to be Faced in Planning Urban Mental Health Services. By William Ryan, Ph. D. Symposium on Mental Health and the Community, Tufts Medical School, Department of Psychology, September 30, 1964.

Basic Reading List on Epidemiology of Mental Disorders. Prepared by Joseph H. Handlon, Ph. D.

Session V: MENTAL HEALTH AS A PUBLIC HEALTH PROBLEM: THE FINDINGS AND RECOMMENDATIONS OF THE JOINT COMMISSION REPORT: IMPLICATIONS FOR PROGRAMMING AND SURVEY OF CURRENT MODELS.

Speaker: Cynthia Harris, M.D., Project Staff.

Resource material:

Distress in the City. Boston Mental Health Survey by William Ryan, Ph. D. Published by Massachusetts Department of Mental Health.

Fact Sheet: Comprehensive Community Mental Health Center Program. U.S. Government publication.

Message from the President of the United States. Relative to Mental Illness and Mental Retardation. U.S. Government Publication.

Session VI: COMMUNITY ORGANIZATION AND SOCIAL CHANGE.

Guest speaker: Arthur Blum, DSW., Professor, School of Applied Social Sciences, Case Western Reserve University.

Resource material:

Diagram of "Barriers to Change."

Session VII: PREVENTIVE INTERVENTIONS: AN INTRODUCTION

Guest speaker: Alfred Bochner, M.D., Department of Psychiatry, Case Western Reserve University and consultant to Out-patient Services, Metropolitan General Hospital, Cleveland, Ohio.

Resource material:

Looking Beyond. Leonard J. Duhl, M.D. Group for the Advancement of Psychiatry, Report #64.

Session VIII: MODEL PROGRAMS: THE ILLINOIS ZONE CENTER MODEL OF A MULTIPURPOSE CENTER. (A systems-oriented approach to the delivery of services for a large urban population, including a review of the primary, secondary and tertiary preventive strategies employed, and the development of professional and non-professional personnel in this system).

Guest speaker: John Bateman, M.D., Director, Read Zone Center, Chicago, Ill.

Resource material:

The End of Isolation: A description of the Charles F. Read Zone Center, Chicago, Illinois. Harold Visotsky, M.D., Arthur Woloshin, M.D., and John Bateman, M.D.

Planning Mental Health Services for a Large Urban Population.

Arthur Woloshin, M.D., Hyman Pomp, Ph. D., Read Zone Center, Chicago, Ill.

Session IX: THE SATELLITE MODEL AS EXEMPLIFIED BY THE LINCOLN HOSPITAL PROGRAM AND IMPLICATIONS FOR NEW PROFESSIONAL ROLES.

Guest Speaker: Magdalena Miranda, MSW., Lecturer and field work supervisor in Community Organization, School of Applied Social Sciences, Case Western Reserve University.

Resource material:

Prevention, Treatment and Social Action: A Strategy of Intervention in a Disadvantaged Urban Area. Harris Peck, M.D., Seymour Kaplan, M.D., and Melvin Roman, Ph. D., Lincoln Hospital Mental Health Services, Department of Psychiatry, Albert Einstein College of Medicine, Bronx, New York.

Paper presented at the 1965 annual meeting of the American Orthopsychiatric Association, New York, New York.

WORKSHOP II - NEW APPROACHES TO TREATMENT: A SYSTEMS APPROACH

The central concept underlying each of the three courses in this project is social systems theory. During the first course on community mental health, we took a look at the mental health system as it operates on the federal, state and local levels and what we heard about some of the new delivery of service models which are attempting to extend coverage to the larger populations in need of service. In this course we familiarized ourselves with treatment strategies which utilize the forces in a system -- be it a group or family system -- to effect change.

The purpose of this workshop was:

a. to sharpen our understanding of the processes which develop in groups, be they work groups or therapeutic groups, and

b. to apply this to the problems of changing our agency and professional roles in implementing new programs and practices.

FORMAT OF WORKSHOP II

A series of small group "laboratory" exercises were designed to facilitate learning about group processes. They were as follows:

1. Communication patterns: The effects of one-way and two-way communication in problem-solving. ("Domino" exercise).
2. Problem-solving behavior in groups: Given a specific task, such as arriving at a consensus about the most important community mental health problem in Cleveland, what are the stages a group goes through in arriving at a decision, and what are the roles taken by individuals in this process? Each group will alternate as participant and observer in this "Fish-Bowl" exercise.
3. Effects of competitive and collaborative styles in problem-solving: The non-verbal "Five Squares" exercise was used to heighten awareness of individual and group styles, and the effects of these styles on outcome.

4. Relationship between assumed roles and task accomplishment: Each small group was given the task of designing a new crisis intervention team, with the following instructions:

> "In this course, we have been learning about the various delivery of service models, including the crisis intervention team as a tertiary preventive method. Write job descriptions and set salaries for four professionals, usually assigned to such teams: Social worker, psychiatrist, nurse and psychologist."

SUMMARY AND EVALUATION OF WORKSHOP II BY STAFF

Participant reaction to the exercises was mixed; some felt the games were interesting and valuable, others found them superficial and only reinforcing what they knew all along. Both the negative and positive reactions were freely expressed and were regarded by the staff as a testing out of our commitment to the value of open and honest communication.

The results from the last exercise (designing a crisis intervention team) enabled us to make some tentative hypotheses about our temporary system. First, from the job descriptions produced by the groups, it appeared that, intellectually, they had accepted some of the new professional role models that had been discussed by some of the outside lecturers in the course on Community Mental Health. Each group designed a mental health team in which the nurse and social worker shared critical decision-making responsibility and authority with the psychiatrist and psychologist. However, salaries were based on traditional scales rather than on functions and tasks performed. Second, there was an easing up of guardedness and defensiveness with each other. Small group interactions were characterized by liveliness and a certain amount of friendly confrontation.

IMPLICATIONS FOR CURRICULUM

Some degree of trust was beginning to build within the group and more risk-taking with each other was evident. Despite some continuing resistance to experience-based learning, many seemed ready to participate more actively. This suggested that the material on new treatment strategies should provide ample opportunity for practicum experiences, so that the participants could try out some of the new techniques through simulations.

We also sensed some fear and resistance to leaving the safe confines of their agencies to go out to deal with crises where they are happening, in the community. Very few had had experiences in dealing with a deeply disadvantaged population, particularly "in situ."

Content during the next nine weeks should include:

... Application of strategies for disadvantaged.

... The theories underlying both the traditional and newer treatment strategies.

... Working with the individual and his system, that is, his family, his peer or therapy group, or his community.

... New roles for professionals.

... The use and training of indigenous workers as expediters in the delivery of service.

COURSE II

NEW APPROACHES TO TREATMENT

Weekly three-hour sessions

Session I: THE PAST, THE PRESENT, AND THE FUTURE: AN INTRODUCTION

The Past: Cynthia Harris, M.D., discussed the individualistic philosophy within which we have operated for the past 150 years that is related to a culture which placed a high value on "rugged individualism." The ways in which we view our professional roles, the treatment methods we use and the ways in which communities have delivered services reflect this individualistic philosophy.

The Present and the Future: Elaine Kepner, Ph. D., reviewed the field-theory of Kurt Lewin, and discussed the applications of this theory to the development of systems-models, which emphasize the inter-relatedness of persons to each other and their environments.

Group discussion focussed on the implications of this model for treatment modalities and professional roles.

Resource material:

Manpower Myths and Realities. George Albee, Ph. D., paper delivered at Annual Meeting of the National Association for Mental Health, Nov. 16, 1967.

Relation of Conceptual Models to Institutional Manpower Requirements. Unpublished paper by George Albee, Ph. D.

Session II: THE FAMILY AS A SYSTEM. THE RULES AND COMMUNICATION PATTERNS WHICH CHARACTERIZE A FAMILY SYSTEM, AND THE IMPACT OF THIS SYSTEM ON THE BEHAVIOR OF INDIVIDUALS IN THE SYSTEM.

Speaker: Joseph H. Handlon, Ph. D., Project Staff.

Demonstration of Family Therapy - Cynthia Harris, M.D., and Elaine Kepner, Ph. D., Project Staff.

Resource material:

Family Therapy: A Review. William Mottola, Ph. D., Psychotherapy Theory, Research and Practice, August 4, 1967.

The Treatment of Patient and Family as a Group: Is it Group Therapy? By Joseph H. Handlon, Ph. D., and Morris B. Parloff, Ph. D. International Journal of Group Psychotherapy, 1962, 12, No. 2, 132-141.

The Family as a Treatment Unit. Virginia Satir. Reprinted from Sixth International Congress of Psychotherapy, London, 1964. Confid. Psychiat. 8:37-42, 1965.

Session III: A PRACTICUM IN FAMILY THERAPY.

The participants were given an opportunity to be members of simulated families, or to serve as a therapist to such families. This was not training, but an opportunity either to work with a family system or to experience the effects of the family rules and communication patterns on one's own perceptions and behavior.

Resource material:

The Emergence of Family Diagnosis and Treatment. Nathan Ackerman, Psychotherapy: Theory, Research and Practice, 4, #3, 1967.

Session IV: ROLE PLAYING AS A METHOD FOR UNDERSTANDING COMMUNICATION PATTERNS AND FOR CHANGING BEHAVIOR.

Guest speaker: Robert Bleeze, Ph. D.

Dr. Bleeze discussed the reciprocal relationship between healthy systems and open communication patterns. Role-playing exercises with participants demonstrated this technique which had been used with the less verbal, "disadvantaged" client.

Session V: NEW WAYS OF SERVING THE UNMET NEEDS. THE NEIGHBORHOOD SERVICE CENTER AND THE INDIGENOUS WORKER.

Guest speaker: Emanuel Hallowitz, MSW., Lincoln Hospital Project, Bronx, N.Y.

Resource material:

The Role of a Neighborhood Service Center in a Community Mental Health Program. Emanuel Hallowitz, MSW. Paper presented at the American Orthopsychiatric Association, Washington, D.C., March, 1967.

The Role of the Indigenous Non-professional in a Community Mental Health Neighborhood Service Center Program. Emanuel Hallowitz, MSW., Frank Riessman, Ph. D. Paper presented at the American Orthopsychiatric Association Meeting, April, 1966.

Session VI: NEW WAYS OF SERVING UNMET NEEDS. NEIGHBORHOOD SERVICE CENTERS IN CLEVELAND.

Participants in the Community Mental Health Project met in small groups with the supervisory staff of the Neighborhood Opportunity Centers, Office of Economic Opportunity, Cleveland, Ohio. These supervisors had been doing outreach work in their communities and had come across situations which dramatically highlighted the service gaps in this community.

This meeting and the following meetings were arranged through the Leadership Development Training Program, Cleveland College, Case Western Reserve University, which had been training the OEO outreach workers.

Resource material:

The Social Service Crisis. Martin Rein. Transaction, May, 1964.

Session VII: NEW WAYS OF SERVING THE UNMET NEEDS. PROBLEMS OF THE OUTREACH WORKER IN RELATION TO THE PRESENT DELIVERY OF SERVICE SYSTEM.

This meeting was a dialogue between the participants in the Community Mental Health Training Project and the supervisory staff and outreach workers in the Neighborhood Opportunity Centers, OEO, Cleveland, Ohio. The format of our meeting was as follows:

Total group was to view two films used in training the outreach worker.

1. WORKING WITH PEOPLE 2. ROLE OF THE NEIGHBORHOOD WORKER

Small group discussions were followed by feedback session of total group to share content of small group meetings.

Session VIII: CURRENT TRENDS IN GROUP TREATMENT METHODS.

Speakers: Elaine Kepner, Ph. D. - Learning in a Group.

Cynthia Harris, M.D. - Use of Groups with the "Disadvantaged."

Joseph Handlon, Ph. D. - Instrumented Leaderless Group Methods.

Reports from participants on use of group methods in their agencies.

Resource material:

Application of Learning Theory to the Treatment of Alcoholics. Elaine Kepner, Ph. D. Quarterly Journal Stud. Alc., Vol. 25, June, 1964.

Gestalt Therapy: A Behavioristic Phenomenology. Elaine Kepner, Ph. D., and Lois Brien, Ph. D., to be published in Gestalt Therapy and edited by J. Fagan and I. Shepard, Science and Behavioral Books, Palo Alto, California, 1969.

Session IX: KEEPING THE SCHIZOPHRENIC IN THE COMMUNITY: TREATING THE INTRAPSYCHIC AND EXTRAPSYCHIC FACTORS.

Speaker: Cynthia Harris, M.D., Project Staff.

WORKSHOP III - CONSULTATION PROCESS AND METHODS

Pre-Work for Workshop III

To obtain feedback relevant for workshop planning, the staff interviewed participants at their respective institutions, two to four weeks before the scheduled workshop. Several findings emerged. In almost all instances, we found that the curriculum had been effective in stimulating a re-evaluation of present programs and practices, and some new plans were being contemplated. It also became clear that there were some critical differences in the interests of administrators and staff persons. Administrators were more concerned with such issues as funding, priority setting, internal organizational problems, and the more general problems of inter-agency collaboration and coordination, especially between the public and private sectors. On the other hand, those in supervisory and training positions were interested in manpower training and in effecting changes relating to delivery of service patterns within their own agencies or between agencies in the community.

The question of staff and participant role definitions also came up in various forms at these interviews. Participants still were struggling with their expectations that this course would be pre-packaged and delivered to them to either accept or reject; the staff was struggling with their expectations for greater involvement and autonomy from the participants.

FORMAT FOR WORKSHOP III

The primary goal of this workshop was to work staff-participant expectations with our outside consultant, Miss Ella Boubitz of Arthur D. Little, Cambridge, Mass.

Sub-groups consisting of 5 or 6 persons were structured on a functional basis: Administrators, practitioners and staff. These groups worked together throughout the workshop on the following issues:

Task I: "What is the role of the consultant at this workshop? What are the expectations held by the client, i.e., the project staff and participants, of the consultant, Miss Goubitz?"

Three client expectations were elicited: We want to learn how to be both a consultant and a consultee; we need to get a clearer view of the real problems and barriers relating to mental health in this community; we are concerned with making this project as fruitful as possible in order to serve our community.

From this feedback on expectations, Miss Goubitz identified the most critical problem in our system as being one of unclear expectations between staff and participants. To get at some of the real issues underlying this problem, a second task was set.

Task II. "What are the basic issues as I see them with regard to this project, with regard to the agencies, and with regard to this community?"

Most participants felt they were getting something valuable for themselves as professionals from the project, but it was not clear how much the agencies, per se, were getting. On the positive side, there had been a number of new developments emerging from this project, as shown by the School Consultation Program which was being planned by Mount Pleasant Community Center and Cleveland Guidance Center; a staff development and training program at Beechbrook Children's Home; and, generally improved referrals between the participating agencies. Impact appeared to be greatest on the smaller agencies and/or on the ones in which the director himself had been involved in the course. Concerning issues in the community, questions were raised on the definition of community mental health. Is it new treatment strategies on primary, secondary and tertiary preventive levels, or is it more broadly based social strategies for changing the total environment? As to the teaching methods used in this course, there was general agreement that the experience-based learnings had been most meaningful and involving, but sometimes personally uncomfortable, that the quality of the lectures were uneven, but the quality and value of the resource material was uniformly excellent.

Around the issues of staff-participant roles and expectations, a good deal of disappointment, anger and frustration was openly and sometimes dramatically expressed by persons from both sides. This confrontation was used by the consultant

to illustrate several points. First, problems cannot be solved within an organization unless there is sufficient trust within the group to openly express feelings, including anger, hostility and disappointment. To the extent that we were able to do this in our project, we were a healthy organization which would be able to generate solutions to the problems with which we were concerned. Second, she pointed out that the lack of coordinated planning in this community and in the mental health field in general is due, in part, to the fact that people don't grapple with the disagreements and conflicts that exist. Without acknowledgement of differences, real collaboration is not possible.

Task III. Some of the basic issues generated by the previous task in relation to the agencies and community could take us off into a variety of directions. Considering who we were and where we were in the project at that time, a feasible goal we could next work on was the question:

"How can we make the next ten-week consultation course most meaningful and productive for ourselves?"

Three recommendations for the consultation course were made: A need for cognitive content on organizational theory and change strategies; cognitive content and practice on consultation methods and skills; further information about the status of mental health plans in the community.

SUMMARY AND EVALUATION OF WORKSHOP III BY STAFF

The four content areas identified by participants were to be stressed in the next course:

.... Organizational theory and organizational change strategies.

.... Organization of the Cleveland Mental Health Community.

.... The consulting process.

.... Implementing plans and change strategies which are beginning to emerge in this group

.... We would also need to focus on the application of these concepts and strategies to the programs, plans and policies in the participating agencies.

COURSE III

CONSULTATION AND ORGANIZATIONAL CHANGE

Weekly Three-Hour Session

Session I: ORGANIZATIONAL THEORY: THE NATURE AND STRUCTURE OF FORMAL AND INFORMAL SYSTEMS.

Guest speaker: Thomas Bier, Ph. D., Assistant Professor, Organizational Behavior, Case Western Reserve University.

Session II: ORGANIZATIONAL CHANGE: STRATEGIES FOR CHANGING SYSTEMS, INCLUDING THE DEVELOPMENT OF TEMPORARY SYSTEMS, USE OF THE "MATRIX" MODEL, AND ROLE OF THE CHANGE AGENT.

Guest speaker: Thomas Bier, Ph. D.

Resource material:

Organizational Theory and Organizational Change. Thomas Bier, Ph. D., Community Mental Health Training Project, Cleveland College, Case Western Reserve University, mimeographed paper, April 4, 1968.

Session III: APPLICATIONS OF ORGANIZATIONAL THEORY AND STRATEGIES: THE CLEVELAND MENTAL HEALTH COMMUNITY.

We had spent the preceeding two weeks hearing about organizational theory and change strategies. In the next two weeks, we focussed more specifically on the application of these organizational skills to our own institutional practices and to the development of collaborative efforts with others in the achievement of mutual goals.

In order for an individual to be able to function in a creatively collaborative way within a complex organizational system, he must become aware of the various component parts of that system; he must learn how they are linked together by formal and informal communication patterns and by various power relationships; he must know what the explicit and implicit goals and values of the system are; and he must become aware of how decisions are made, and upon what basis. Above all, the individual must learn ways in which the system can be influenced.

How could each of us, through joining with others, bring about a change? What are the points of leverage and how can colleagues be found that have shared values who, by working together, could create a "critical mass" of sufficient power to exert the needed influence?

The meeting that week was devoted to information giving, and sharing around the questions raised in the above paragraph. Specifically we were interested in exploring:

1. What are the comprehensive mental health goals of this community?
2. How do our agency's plans and programs relate to the total community plans?
3. How can collaboration between the private and public sectors be encouraged?
4. What is the function, authority and structure of the newly created Cuyahoga County Community Mental Health and Retardation Board?
5. What is the relationship between the Cleveland (Region I) Mental Health plans and the Board?
6. What are the regulations being formulated by the State of Ohio that will serve as guidelines for this Board?

Several resource persons from the project were present to share their "pieces" of information and knowledgeability with us:

William Warner, Director, Beechbrook Children's Home.

Milton Matz, Member, Cuyahoga County Community Mental Health and Retardation Board.

Arthur Blum, Professor, School of Applied Social Sciences, Case Western Reserve University.

Marshall Begley, Executive Director, Cleveland Mental Health Association.

Session IV: APPLICATIONS OF ORGANIZATIONAL THEORY AND CHANGE STRATEGIES: THE AGENCIES IN CLEVELAND AS REPRESENTED BY THE PARTICIPANTS IN THIS PROJECT.

Reports from the twelve agencies in this program on implementation of new programs or plans.

SESSION V: APPLICATIONS OF ORGANIZATIONAL CHANGE STRATEGIES IN A COMPLEX INDUSTRIAL ORGANIZATION. A REPORT ON A LONG-RANGE PROGRAM TO CHANGE ATTITUDES AND ORGANIZATIONAL PROBLEM-SOLVING AT THOMPSON-RAMO-WOOLRIDGE, INC., CLEVELAND, OHIO.

Guest speaker: James Dunlap, Vice-President, Human Relations, at Thompson-Ramo-Woolridge, Inc., Cleveland, Ohio

Resource material:

An Approach to Career Development. James Dunlap and Sheldon Davis. Mimeographed paper, at TRW, Inc., Cleveland, Ohio

An Organic Problem-Solving Method of Organizational Change. Sheldon Davis, Journal of Applied Behavioral Sciences, Vol. 3, #1, 1967.

SESSION VI: THE CONSULTATION PROCESS: PHASES OF THE CONSULTING PROCESS: THE ROLE OF THE CHANGE AGENT AND HIS SKILLS AND METHODS.

Speaker: Joseph H. Handlon, Ph. D., Project Staff.

Resource material:

The Consulting Process. Joseph H. Handlon, Ph. D. Mimeographed lecture prepared for the Community Mental Health Training Project, Cleveland College, Case Western Reserve University, 1968.

The Role of the Psychologist as a Mental Health Consultant in Prevention. Robert Reiff, Ph. D. Second Joint Colloquim on Community Mental Health in Ohio. Ohio Department of Mental Hygiene, March, 1966.

SESSION VII: A PRACTICUM IN CONSULTING.

We worked in three-person groups, exchanging roles of client, consultant and observer. The consulting issue was identified by each "client," and was to reflect some current work issue.

SESSION VIII: EXPLORING MENTAL HEALTH MODELS AND STRATEGIES FOR CLEVELAND.

We took a closer look at the needs and resources of Cuyahoga County as identified in Interaction for Mental Health: Report of Region I, Comprehensive Mental Health Planning Committee. Out of this, we generated a list of critical problems that we could begin to work on at the final workshop.

Speaker: Cynthia Harris, M.D., Project Staff.

Resource material:

List of needs and resources in Cleveland.

Summary prepared by Cynthia Harris, M.D., for Community Mental Health Training Project, Cleveland College, Case Western Reserve University.

WORKSHOP IV - FINAL WORKSHOP FOR FIRST YEAR

Workshop aims of this final session were: To attempt to move the participants into some action planning steps around the preventive needs for this community which they identified at the last weekly meeting; to use the workshop process to add to the learnings about task-group effectiveness; to clarify future role relationship of project staff and participants, and build in any follow-up mechanisms required.

FORMAT OF WORKSHOP IV

The Consultation Course meeting at the last weekly meeting was devoted to a study of needs and resources in Cleveland as reported by the Interaction for Mental Health Report, Cleveland Mental Health Planning Committee. The participants in this program felt that preventive needs and services had been only superficially noted in this report and they proceeded to list a series of 13 critical preventive needs in this community. The staff summarized these needs into 4 basic concerns which became the task group issues to be worked at the final workshop:

1. Strategy for building mental health: Community development of neighborhood competence, including resident participation and collaboration with caretakers in the community.
2. New roles for mental health workers, professional and non-professional, including training needs and use of consultation teams in specialized areas.
3. Comprehensive community mental health with children; new treatment and preventive strategies in schools, agencies and institutions.
4. Administrative collaboration in planning and programming on the state, county and local levels.

Membership in each task group was by participant choice. Feedback sessions in which each group shared their thinking with the total group alternated with meetings of individual work groups. Two "outside consultants," Thomas Bier, Ph. D., and Sherman Grinnell, Ph. D., of the Organizational Behavior and Administration Department of Case Western Reserve University assessed and discussed their observations of our functioning as working groups.

SUMMARY OF WORKSHOP IV BY PROJECT STAFF

The group who worked on community development and mental health became aware of their general ignorance and unrelatedness to the whole concept of neighborhood mental health. They recognized mental health needs primarily in terms of the problems that came to them at their desks, without understanding the environmental factors, particularly the neighborhood resources which could be utilized in comprehensive service. They felt that mental health strategies needed to be related to the actual needs of actual communities -- and that this could only be done if geographic boundaries and responsibility for service in that area would be clearly established. They recommended that the curriculum for the following year include more about "community," and that the participant group be expanded to include a broader spectrum of caregiving services.

Those concerned with new roles for professionals outlined a job description and training program for the role of mental health expediter which they felt was relevant to this community. They would work on developing this further in the fall of 1968, and explore implementation possibilities at that time.

Two groups merged because of similar issues and concerns about comprehensive care for children. The administrators' group as a whole felt the need for some continuing mechanism for the type of cross-consultation between agencies, that they had experienced during the workshop. As one member put it, "how can we further actualize this start we have made in the direction of being a community of resources to each other?" The project staff offered to provide administrative services to this core group to maintain and expand the "community of resources" concept, and to meet with them again in the fall to discuss ideas for an administrators' conference. Directors of two agencies involved with children's services set future meetings to discuss collaborative programs.

COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT

CASE WESTERN RESERVE UNIVERSITY

CLEVELAND COLLEGE

SECOND YEAR: 1968-1969

STAFF

Elaine Kepner, Ph.D.	Director
Joseph H. Handlon, Ph.D.	Associate Director
Cynthia Harris, M.D.	Associate Director
Rose Stevenson	Secretary

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Frances Baker, R.N., M.A.	Department of Psychology, CWRU
Lois Brien, Ph.D.	Assistant Professor, Department of Speech Communication, CWRU

GRADUATE STUDENTS

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Robert Sprague, M.A.	Department of Psychology, CWRU
Carl Weitman, M.B.A.	Department of Psychology, CWRU

CASE WESTERN RESERVE UNIVERSITY

Cleveland College

COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT

Second Year Of Project

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COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT

Cleveland College, Case Western Reserve University

SECOND YEAR CURRICULUM 1968-69

COURSE I - COMMUNITY MENTAL HEALTH CONCEPTS

One two-day workshop and
nine weekly three-hour sessions.

COURSE II - NEW STRATEGIES IN COMMUNITY MENTAL HEALTH

One two-day workshop and
nine weekly three-hour sessions.

COURSE III - STRATEGIES OF PLANNED CHANGE

One initial two-day workshop
nine weekly three-hour sessions and
final two-day workshop: A Problem-Solving
Consultative Model as a Change Strategy.

OPENING WORKSHOP - INTRODUCTION AND ORIENTATION

During the next nine months, we were to be learning the what and how of community mental health. The what included substantive issues, e.g., the goals of community mental health, new delivery of service models, manpower utilization and consultation strategies.

The how was to be concerned with the change process necessary to move ourselves and our systems into this new area. We were to be working with content and process during this workshop as we were to continue to do throughout the year. Brief lectures served as an introduction to community mental health and some of the issues and problems in implementation. Small groups were used for two purposes: a) to discuss the implications of the content for our agencies and for the mental health system in Cleveland and, b) to develop an awareness of the process that goes on in task groups meeting together for the first time.

FORMAT OF WORKSHOP I

1. Community Mental Health:

   A contrast between the old and the new models.

   Elaine Kepner, Project Director

   Systems theory and community mental health.

   Joseph H. Handlon, Associate Project Director

   Barriers to change in individuals and systems.

   Arthur Blum, Professor of Social Work, Case Western Reserve University

   Social Etiology and high risk populations.

   Cynthia Harris, Associate Project Director

2. Introducing ourselves to each other, who we are, what our agencies do.
3. Small group discussions.
4. General summary sessions.
5. Overview of the nine month course, including content, methods and purposes of field work experience.

SUMMARY AND EVALUATION OF WORKSHOP I BY STAFF

The following questions and issues needed to be fully explored in this next course in the lectures and discussion sessions:

.... what is community mental health?

.... what is a community

.... what are the specific community mental health problems as they exist in our community in terms of unmet needs and use of existing resources?

.... how can we build a more comprehensive network of services with existing resources?

Concerning the proposed field work experience, the participants appeared open to the idea. Because of the large size of the participant group, the staff would need to work closely with the task forces and with each other to co-ordinate this effort. We anticipated a rise in "drop-outs" at that time, and it had to be the responsibility of the task group leaders to maintain the level of involvement.

COURSE I

COMMUNITY MENTAL HEALTH

Weekly three-hour sessions

Session I: EPIDEMIOLOGY: BASIC CONCEPTS AND MAJOR FINDINGS.

Identification of "high-risk" groups - who they are and where they are; implications of epidemiological findings to present delivery of service systems.

Resource material:

Summary Tables and Lecture Outline. Prepared by Joseph H. Handlon

Facts to be Faced in Planning Urban Mental Health Services. Willaim Ryan, Ph. D. Symposium on Mental Health and the Community, Tufts Medical School, Department of Psychology, September 30, 1964.

Staff lecturer: Joseph H. Handlon, Ph. D.

Session II: COMMUNITY MENTAL HEALTH: A PUBLIC HEALTH APPROACH.

The social planning and philosophy underlying the national, state and local plans; the "treatment" and the "preventive" models; guidelines as they now exist; mental health planning in Cleveland.

Resource material:

Community Mental Health: Means or end? Harry R. Brickman, M.D. Reprint from Psychiatry Digest, June, 1967.

Looking Beyond. Leonard H. Duhl, M.D. Group for Advancement of Psychiatry Report #64.

Distress in the City. Summary report to the Boston Mental Health Survey, 1960-1962. William Ryan, Ph. D.

Staff lecturers: Elaine Kepner, Ph. D.

Frances Baker, M. A.

Session III: A COMMUNITY AS A SYSTEM

The parameters of a community: How it is organized; how decisions are made; the formal and informal structures and their influence on change; the role of citizen participation in change efforts; catchment areas and neighborhoods.

Resource material:

Farewell to Integration - Hail to Co-Existence. W.H. Ferry. Publications of the Center for the Study of Democratic Institutions, The Center Magazine, March, 1968.

Lecturer: Raymond Koleski, MSW., Community Organization, School of Applied Social Sciences, Case Western Reserve University.

SESSION IV: BUILDING WORKING GROUPS: THE COMMUNICATION PROCESS AS IT RELATES TO TASK-GROUP EFFECTIVENESS.

Resource material:

The Family as a Treatment Unit. Confin. Psychiat., 9:37-42, 1965.

Lecturer: Virginia Satir, Former Director of Training, Mental Research Institute, Palo Alto, California.

SESSION V:
THROUGH
SESSION IX: FIELD WORK IN THE COMMUNITY.

The development of community mental health programs that are relevant to the needs of the people being served requires a knowledge of the people in that community and the resources, or lack of them, therein. The purpose of this field work was to gain a better understanding of community mental health by becoming better acquainted with three areas in this city that are in rapid and critical stages of transition: namely, Glenville, Central, and Tremont-Near West Side. We were to go into these communities as social anthropologists:

...to increase our understanding of the social and political structures in the communities and of the needs, existing resources and service gaps;

...to explore strategies for developing more comprehensive and effective networks of services in which our "back home" agencies could participate.

As we went out into the communities, it was important to remember that at this point, we had nothing to offer except our interest and need to know.

The kind of picture which we were going to be able to piece together about these areas would be sketchy and incomplete. However, our exposure to this data would give us a more realistic and comprehensive perspective about community mental health as well as the potentialities of our own individual programs to relate more closely to some specific community needs.

Our general task during the next two months was to inform ourselves about four basic sub-systems in the target communities: The educational, economic, housing and mental health resources. We could learn about these sub-systems talking to leaders and people who were in the various organizations in the communities; by referring to information already gathered in surveys and reports; and by going into the community and getting a feel for characteristics of the area.

Participants were divided into three task forces as follows: Team A was assigned to Glenville; Team B was assigned to Tremont-Near West Side and Team C was assigned to Central.

The schedule for the field work portion of this program was:

Session V: Each team met in the project offices to determine how they were going to go about gathering data and planning their assignments for the next three weeks.

Session VI-VII-VIII: Work in the field.

Session IX: Each team met again at the project offices to prepare to report on their findings to total group at the Workshop scheduled for the following month.

COURSE II

NEW STRATEGIES IN COMMUNITY MENTAL HEALTH

WORKSHOP II: THE PROCESS OF COLLABORATION

At this workshop the content was to be organizing the data gathered from the field experience. Each of the task groups: a) reviewed the data gathered and determined whether it was sufficient to go on to the next step which was to b) assess the major mental health needs of the community. This information was shared with the total group. The staff suggested the following data-gathering categories for organizing the material.

The Community

Population characteristics

Economic bases and current status

Education

Housing

Organizations and institutions

The political structure (formal and informal power and decision-making structures)

Socio-economic problems

Mental Health Services

Availability of services

Utilization of services

Most pressing needs of the community

The third step was to identify some changes that could be made to improve the mental health services in the particular community being studied. These changes were to be feasible, that is, within the capability of the existing agencies and resources. The questions we needed to ask ourselves as we began to identify these changes were: What do I want to do? What can I do? With whom do I need to collaborate to implement these changes?

We might not complete this third step at this workshop, but we would be able to start thinking about the implications of the data gathered for the programs in our agencies.

The Process

Miss Ella Goubitz, of Arthur D. Little, Cambridge, Massachusetts, was to act as our consultant to help us examine our "process" as we went about working in task groups on the community reports. Our own group was considered a model of the communities we had been studying in terms of diversity of needs, points of view, motivations, skills and knowledge. We were to be using this workshop to develop collaborative skills and team effectiveness by evaluating the way in which we worked as a group.

SUMMARY AND EVALUATION BY STAFF - WORKSHOP II

In terms of task accomplishment, we had hoped to get through three stages with regard to the community reports: a) organizing the data, b) assessing major mental health needs, and c) identifying feasible changes. Two of the task groups needed to do more data collection before they were ready to go on, and all three were still working on steps (b) and (c). We saw the need to provide time during the subsequent few weeks so that this task could be completed. The staff saw the need to shift from role of consultant to coordinator in order to facilitate the completion of these reports.

The staff was still being "dumped on," but the hostility and criticism had become overt and openly expressed. Several attitudinal problems noted earlier persisted. There was continued resistance to participative learning and lack of perceived need for change, either on an agency or individual level. The community experience had reinforced the fear and guilt felt by some in moving out into the community. The attitudes about "process" learnings were diverse; some saw the relevance to their own situations immediately, others were impatient but tolerant, and some regarded it as a complete waste of time.

On the positive side, the sharing of community data at this workshop built up some healthy competitiveness between the groups, and a sense of cohesiveness and shared concerns was beginning to emerge within the groups. To promote a sense of community in the total group, however, we needed to spend some further time.

COURSE II

NEW STRATEGIES IN COMMUNITY MENTAL HEALTH

Weekly Three-Hour Sessions

SESSION I: FIELD WORK REPORTS: EVALUATION OF HARD AND SOFT DATA.

The three task groups met to continue the workshop tasks, to determine further informational needs, make assignments, etc.

SESSION II: NEW PROFESSIONAL ROLES AND PRACTICES IN A SMALL AGENCY, INCLUDING THE ABOLITION OF CLINIC WAITING LISTS.

Lecturer: Henry Altenberg, M.D., Director of Child Guidance Clinic, New Britain, Connecticut.

Dr. Altenberg discussed the new model developed in his agency to facilitate service to children and families. He also demonstrated the use of psychodrama techniques as a way of working intra-agency change issues.

SESSION III: FIELD WORK REPORTS: UNMET NEEDS.

Task group began process of summarizing data with particular stress on a specific statement of unmet needs in the three neighborhoods.

SESSION IV: FIELD WORK REPORTS: NEW WAYS OF MEETING THE NEEDS.

Final reports were to include some possible new and practical solutions to the problem of unmet needs in the three communities under study. The important question was: Can existing resources be better utilized to meet the needs either via collaborative inter-agency programs, consultation and education, training of para-professionals?

SESSION V: THE LINCOLN CENTER NEIGHBORHOOD SATELLITE MODEL.

Lecturer: Emanuel Hallowitz, MSW., Director, Lincoln Hospital Mental Health Services, Bronx, New York.

Dr. Hallowitz discussed the mental health services in the hospital and at the outreach offices; the building of relationships with the residents and the training of indigenous workers.

Resource material:

The Role of a Neighborhood Service Center in a Community Mental Health Program. Emanuel Hallowitz, MSW., paper presented at the American Orthopsychiatric Association, Washington, D.C., March, 1967.

Issues and Strategies in the Use of Nonprofessionals. Emanuel Hallowitz, MSW., presented at NASW Symposium, Nat'l Conf. of Social Welfare, San Francisco, Calif., May 25, 1968

The Role of the Indigenous Nonprofessional in a Community Mental Health Neighborhood Service Center Program. Emanuel Hallowitz, MSW., American Journal of Orthopsychiatry, July, 1967.

SESSION VI: FIELD WORK REPORTS: FINAL SUMMARY.

Individual reports within task groups were to be submitted to total group. Final report was to be a joint effort and product of total group. Task Group to select a reporter to present summary of material at the Administrators' Conference, February 28, 1969.

SESSION VII: SAN MATEO MENTAL HEALTH PROGRAM: A COUNTY-WIDE SYSTEM.

Lecturers: Joseph H. Handlon, Ph. D., Project staff

Elaine Kepner, Ph. D., Project staff

Dr. Handlon discussed the social and economic characteristics of the area, the development of county programs and services, including research and evaluation aspects, and the relations with the California State Department of Mental Hygiene Institutions.

A report of the San Mateo consultation and educational services was reviewed by Dr. Kepner.

SESSION VIII: COMMUNITY MENTAL HEALTH TRAINING PROJECT: A CRITIQUE AND EVALUATION OF ADMINISTRATORS' CONFERENCE OF FEBRUARY 28, 1969.

SESSION IX: MYTHS, MODELS AND MANPOWER: NEW CONCEPTS AND NEW ROLES IN MENTAL HEALTH.

Lecturer: George Albee, Ph. D., Chairman, Department of Psychology, Case Western Reserve University.

Resource material:

Emerging Concepts of Mental Illness and Models of Treatment: The Psychological View. George Albee, Ph. D., American Jour. Psychiatry, 125.7, January, 1969.

WORKSHOP III - CONSULTATION: PRINCIPLES AND PRACTICES.

Consultant: Miss Ella Goubitz of Arthur D. Little, Cambridge, Mass.

This two-day workshop was a training session on consultation methods as applied to mental health situations. No pre-packaged format had been arranged. Rather, we, the participants and staff, were to function as a client system, developing the agenda for the workshop when we met with our consultant. This would enable us to learn about consulting from observing, and participating in, the development of this consultative relationship.

THE FORMAT THAT EVOLVED

Definition of a consultant and development of an agenda.

After some brief introductory remarks from the staff and from our consultant, small groups met to define the role of consultant in their own terms and generated a list of responses in anwer to the question, "What do I expect from our consultant in these next two days?" As this data was shared in the total group, it was clear the consultant's role got defined by the client's expectations. Although the list of expectations generated by the participants was diverse and demanding, one expectation was sufficiently pervasive and realistic to be dealt with in the next two days. This

expectation was, "I want to develop some understanding of what a consultant does, and I want to learn this by doing."

PRACTICUM EXPERIENCES

Several exercises were developed around real and present problems that a participant was facing in his work situation and for which he wanted some help. Initially, we started off with a demonstration by our outside consultant, Miss Goubitz, and then divided into triads, with the roles of client, consultant and observer being rotated.

WHAT WAS LEARNED, AS SUMMARIZED BY PARTICIPANTS

1. The consultant clarified expectations. Did the client want help, support, reassurance, advice?
2. The consultant clarified ownership of the problem. Did the person who calls you in want help, or is he asking you to come in to help others?
3. The consultant assisted in clarifying the problem. The presenting problem, as in psychotherapy, is often not the real problem. The consultant is concerned about the problem as the client defines it.
4. The consultant is one who establishes a helping relationship with the client. One can help only when one is perceived as a helper. Asking for help is a difficult thing for most people.
5. The consultant does not need to have answers, or to give advice, or be an expert in content areas. He is a facilitator of change and a teacher of the problem-solving process. He assists in clarifying the problem, defining solutions and alternatives and in assessing outcomes.
6. Consultation is a two-way communication process. The consultant needs to hear, to give clear messages and to ask questions when things are unclear to him.
7. The consultant needs to create a psychological climate in which it is safe to be open and honest, to explore alternatives and take risks.

EVALUATION BY PARTICIPANTS

The exercises were extremely helpful, particularly the rotation of roles from consultant, to client, to observer. Experiential learning is effective; people can learn and develop concepts based on their experiences.

EVALUATION BY STAFF

The workshop was most productive and satisfying for participants and they were able to see the transfer of learning from the role of therapist to the role of consultant. In the relatively safe atmosphere of the workshop, they were able to share their confusions and difficulties in the consulting role, particularly their tendency to offer solutions before they really heard the problem.

The staff had to deal with their feelings about not being accepted in the consultative role by the participants. We are internal change agents in our "temporary system," and it requires an outside person to come in and be accepted by the group as an expert. We rationalized or explained this on the basis of the many roles we have played in the project -- teachers, group leaders, group members, process observers, administrators -- which precludes our being perceived in the pure role of "consultant." The workshop was most gratifying to us on several counts. The participants learned what they came for, they were involved and had fun in the learning process, and they finally had accepted the experience-based learning model.

COURSE III

THE STRATEGIES OF PLANNED SYSTEMS CHANGE: MOVING FROM THE OLD TO THE NEW MODELS

The eight sessions of this part of the training project dealt with an elaboration of various strategies for planned systems change relevant to dealing with mental health problems. The topic areas covered during this period were:

....Building inter-agency and total community coordination; what is an appropriate collaboration model? How can such collaboration be developed? Inter-agency collaboration as an example of "center without walls."

....The consultation process; the consultant's role in planned change process; personal aspects of the systems consultation process; mental health agency consultation.

....Organizational theory; formal vs. informal organizational structure; inter-relationships between structure and function of organizations; implications for mental health organizations; communication and influence patterns in organizations; internal and external pressure for change in mental health organizations; relationships with community.

....Strategies for organizational change; the role of the internal-and external-change agent; relevance of organization's members' "ownership" in organizational change.

SESSION I: NEW MODELS IN PSYCHIATRIC CONSULTATION.

Lecturer: Carl Whitaker, M.D. Professor of Psychiatry, School of Medicine, University of Wisconsin.

Resource material:

The Clinical Psychologist and Mental Health Consultation. A.J. Bindman. Progress in Clinical Psychology, Vol. 7, N.Y., Grune and Stratton, 1966.

The Mental Health Service as Conspirator. Thomas Gladwin, Ph. D. Community Mental Health Journal, Vol. 4 (6), 1968.

SESSION II: THE MAIMONIDES HOSPITAL STORY: CHANGING A TRADITIONAL PSYCHIATRIC SERVICE INTO A COMMUNITY MENTAL HEALTH CENTER. (A)
USE OF AN INTERNAL CHANGE AGENT IN THE CHANGE PROCESS. (B)

Lecturers: Montague Ullman, M.D., Director, Maimonides Medical Center.
Eugene Nadler, Ph. D., Staff, Maimonides Medical Center.

Resource material:

A General Hospital Program for Serving Community Mental Health Needs. Mark Tarail, DSW. Reprinted from HOSPITALS, Journal of the American Hospital Association, Vol. 42, February 1, 1968.

SESSION III: THE CONSULTATIVE PROCESS.

Lecturer: Joseph H. Handlon, Ph. D. Staff, Community Mental Health Training Project.

Resource material:

The Consultation Process: Joseph H. Handlon, Ph. D. Mimeographed paper prepared for Community Mental Health Training Project, 1968.

SESSION IV: ORGANIZATIONAL THEORY AND DEVELOPMENT.

Lecturer: Sherman Grinnell, Ph. D. Associate Professor, Engineering and Design Center, Department of Organization and Administration, School of Management, Case Western Reserve University.

Resource material:

Organizational Theory and Change Strategies. Unpublished paper by Sherman Grinnell, Ph. D.

SESSION V: MODELS OF COLLABORATION.

Lecturer: Sherman Grinnell, Ph. D.

Resource material:

The Development of Creative Interprofessional Collaboration. Unpublished paper by Sherman Grinnell, Ph. D.

SESSION VI: APPLICATIONS OF ORGANIZATIONAL CHANGE THEORY TO A LARGE INDUSTRIAL SYSTEM.

Lecturer: James Dunlap, Vice-President, Human Relations, Thompson-Ramo-Woolridge, Inc., Cleveland, Ohio

Resource material:

An Approach to Career Development. James Dunlap and Sheldon Davis. Mimeographed paper.

An Organic Problem-Solving Method of Organizational Change. Sheldon J. Davis. Journal of Applied Behavioral Sciences, Vol. 3, #1, 1967.

SESSION VII: PRE-WORK FOR WORKSHOP.

Consultation with participants from Community Mental Health Training Project, 1967-1968. Alumni Meeting.

SESSION VIII: THE INTEGRATION OF THE ILLINOIS ZONE MODEL WITH EXISTING COMMUNITY RESOURCES.

Lecturer: John Bateman, M. D., Superintendent, Read Zone Center, Chicago, Illinois.

Resource material:

The End of Isolation. John Bateman, Arthur Woloshin, Harry Visotsky, M. Ds. A description of the Charles Read Zone Center.

FINAL WORKSHOP IV - A PROBLEM-SOLVING CONSULTATIVE MODEL AS A CHANGE STRATEGY

Over the past ten weeks we had been learning and practising skills in collaboration and consultation. In this last workshop we applied these learnings to one or more of the new programs which had been evolving within and between agencies in this training project. Our trainer was Miss Ella Goubitz.

FORMAT AND METHOD

The following eight-stage problem-solving model was applied to a "case study" -- a new program which was being considered by one of the agency directors on which he wanted some consultation.

The problem solving model:

1. Stating the initial problem.
2. Collecting new data to assist in re-defining the problem.
3. Making a provisional diagnosis.
4. Devising problem solutions.
5. Choosing a solution.
6. Planning the necessary actions and considering consequences: what do we need to do? Who takes what piece of the action? What's the sequence? How much time do we need? Do we have enough resources?
7. Taking the action.
8. Evaluation: Did we solve the problem? If not, the cycle begins again, the problem is restated, new data collected, etc.

The "problem" we worked on, as presented by the agency director was this:

> I have recently noticed in our monthly statistics that our agency has been receiving an unusual number of referrals from two schools in our area which peak during the months of October and February.

> The referrals are meaningful and appropriate for our agency and run the usual gamut -- poor social adjustment, problems in classroom behavior, underachieving, and the like. We have been handling these cases on an individual basis, but we have been wondering whether we might try some different strategies. What could we do to get some clearer picture of the source and reason for these referrals? Is there some way in which we can work preventively?

The total group was divided into three consulting teams which could ask 3 questions at a time from a group of informants. Sources of information were the agency who owned the problem and two school psychologists who were familiar with the community and the school population. Each team was to collect data, come up with some provisional diagnosis and tentative problem solutions.

The teams encountered similar problems to the ones they had faced as individual consultants in the last workshop. They tended to make premature diagnoses before collecting sufficient data. They were reluctant to ask simple questions, and interpreted the answers they received. They collected data in terms of the way <u>they</u> saw the problem rather than as the consultee perceived the problem.

Despite these difficulties, the teams came up with some creative provisional diagnoses; further questions which could be asked to test out these formulations and some tentative strategies for action. It was learned that the schools from which the referrals were coming served two large federal housing projects in which most of the families were on Aid to Dependent Children. The primary problem, as the consulting teams saw it, was the discrepancy between middle-class school norms and child-rearing norms of the families. The school was seeing the problems in terms of

individuals, and the agency was accepting referrals on this basis. If the problem was one of differences in cultural expectations and/or unpreparedness for school entrance, several alternative solutions suggested themselves -- parent groups for pre-schoolers, a co-operative nursery school for the children, consulting with the teachers in the school to assist them in working with these children.

The consultee, after this feedback, immediately saw the problem in a broader context involving the school, the housing project and the County Welfare Department, all of whom contribute to the problem and/or are able to function as resources in developing preventive strategies. The next steps then appeared to be contacts with the school principal, the housing project manager, the County Welfare Department, and possibly the teachers, to further explore the problem and some possible solutions.

EVALUATION OF THE WORKSHOP BY THE PARTICIPANTS

Both the "consultee" and the "consultants" felt that the learning-by-doing was extremely helpful and productive. They were able to understand the developmental process of problem-solving and to take a look at their own behavior in relation to the process.

EVALUATION OF THE COURSE BY PARTICIPANTS.

They recommended that the courses be given in reverse order, since the material on organizational theory and change strategies presented during the last course on consultation set a theoretical and practical framework from which they could better understand the change problems in implementing community mental health. In terms of the teaching methods, they admitted their earlier resistance to the participative learning model, but found these sessions, particularly the two-day workshops, to be the most meaningful experiences for them. . . .The ways in which they worked together at the workshops broke dowm many of the barriers that had existed between

them, and they believed that this had facilitated the development of some joint projects between agencies. Some of the most important learnings for them from the project in general can be summarized as follows:

....They were more able to communicate clearly with each other, and this generalized to their communications with colleagues in their back-home organizations.

....They felt able to take the risk of trying something new, and learning from that experience if the effort "failed."

....They felt more familiar with the "community" because of their contacts with each other in the project and their field work experience.

....They realized that change is a process which takes place over time, is often resisted, and can be facilitated by linking up with like-minded colleagues in the system.

....They saw systems change as a more complex problem and process, and while they were less grandiose now about expectations, they felt more capable of determining what was feasible of moving and moved into new areas.

ADMINISTRATORS' CONFERENCES

During the two years of the Training Project, both staff workers and individuals with administrative responsibilities were among the participants. Toward the end of the first year we became aware that those participants with administrative responsibilities had special needs which, if they were to be met, required different sorts of training activities. Further, during the first year of the Project, an important event took place on the Cleveland mental health scene; this was the implementation of the local Cuyahoga County Community Mental Health and Retardation Board, which received the mandate to determine the way in which available local, county, and state matching funds were to be spent. An announced policy of the Board had been to encourage inter-agency linkages wherever possible, so that local administrators came to need, -- more clearly, even than before, -- a forum in which they could foster the linkages which were called for by the new Board.

We therefore decided to sponsor a series of Administrators' Conferences during the second year of the Project, 1968-1969. We felt that these Conferences answered, in some degree, the need felt in the local community for a neutral forum where agency and hospital administrators could share common interests, work on common problems and plan some action steps.

The basic group invited to the Conferences were administrators who had either participated in the Project themselves or who had sent some of their staff members as participants. It was felt that these people would already be familiar with the educational philosophy of the Project and would be ready to participate actively and collaboratively in making decisions about the topics and methods of the conferences. Administrators from agencies and hospitals not directly affiliated with the Project were occasionally invited to attend. Four day-long Administrators' Conferences were held during the academic year of 1968-1969 and fifty administrators participated. The average attendance per conference was about thirty participants.

At the first Administrators' Conference, held in the fall of 1968, the first step was to have the participants break up into small groups to generate lists of problem areas in which they would have some interest in working. Three major areas of concern emerged: 1) inter-agency collaboration and cooperation around mental health issues; 2) ways and means of coping more effectively with the problems of the disturbed children and their families; and, 3) the development of methods and strategies for getting closer to the community, and of involving residents in appropriate ways in agency decisions and service delivery patterns. At the end of this first conference it was decided to move ahead on the last concern -- getting closer to the community -- and a Steering Committee was set up, consisting of the Project staff plus seven participants.[1].

During the second Conference, held in the early winter, the Steering Committee planned to give each agency an opportunity to present what they were doing by way of plans for dealing with mental health problems in the many deprived areas of our community and to have residents of these areas react to these plans. What resulted was a hard confrontation session, with little opportunity to develop provider-consumer collaboration.

As a result, the Steering Committee decided that the third Administrators' Conference would be devoted to spelling out possible roles of community residents in helping the agencies develop closer and more meaningful ties to the local community. Several agencies presented current programs which then led to a general discussion the question: What are the appropriate roles of community residents in shaping the policies of agencies and hospitals? A need was felt to learn more about the possible

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1. Dr. William Warner, Beechbrook Childrens' Home
Mrs. Murtis Taylor, Mt. Pleasant Community Center
Dr. Mildred Shelley, Marymount Community Mental Health Center
Mr. Charles Dalton, Community Information Service
Mrs. Marjorie Hall, Cuyahoga County Welfare Department
Dr. Robert Conquest, Hough-Norwood Family Health Care Center
Mr. Steven Minter, Cuyahoga County Welfare Department

means by which genuine collaboration might be brought about.

Thus, during the fourth and final conference of the year, a major portion of the day was devoted to a review of what had been learned from the experience of a number of different organizations who have attempted to broaden the base of responsibility and decision-making to include consumer representation. Specific strategies for the development of citizen participation in other settings, e.g., in Model Cities efforts, were discussed.

During the year, the Steering Committee itself had become a spirited group of colleagues. When the demonstration part of the Training Project ended in the spring of 1969, the Steering Committee decided to continue meeting and the Project staff agreed to continue to coordinate the group.

The Committee has continued to meet regularly at monthly intervals. The main purpose of these meetings has been to create an appropriate means by which to fulfill the need for an ongoing forum for local mental health administrators. At the second meeting held in 1970, specific plans for such an ongoing were developed. It was decided to call the new group the Mental Health Exchange; this group was to be made up of the members of the previous Steering Committee plus others in the community who expressed interest in joining such a group. It was also decided that the group would continue to meet monthly and that the meetings would be of an informal nature with no pre-set agenda. The Project staff were to continue to act as coordinators and as hosts at the luncheon meetings. To date there have been three meetings of the Mental Health Exchange and a number of topics have been discussed. There has been considerable interest in recent developments in the community's attempt to deal with the local drug problem.

Although the future of the Mental Health Exchange remains somewhat uncertain, the group wishes to continue, and the plans are for the various participating agencies to act as rotating hosts for the monthly meetings when the Community Mental Health Training Project no longer exists. It is quite clear that there is a need for such a group to continue to meet on an informal basis and to exchange views and to plan action steps to deal with problems of mutual concern.

Part Three

APPENDIX

O U T C O M E

Details of Impact on Participants as Assessed by Research Instruments

During both years of the training project, research instruments were administered to the participants before the training started and again immediately after the training project was completed. In this way, objective measures of attitudes towards community mental health, perceptions of problem areas encountered in community mental health, and perceptions of the relevance of local agencies in community mental health could be obtained. Complete "before" and "after" data were obtained on 27 participants the first year and 29 participants the second year. Since complete "before" and "after" data was not available from many participants, there remains the question as to whether the results obtained from those that did complete the instruments were representative of those that did not.

The results obtained from the two years of the project are rather different, so they will be reviewed separately as each instrument is discussed.

1. The Semantic Meaning of the Concept "Community Mental Health."

The version of the semantic differential developed by Schulberg and Baker[1] was used to analyze the concept "community mental health." Individual measures on three factors, Evaluation, Activity, and Potency are derived from the instrument.

In neither the first year nor the second year of the project was there any change over time in the Evaluation factor. This indicates that there was no change in the degree of favorableness or un-favorableness with which the participants viewed the concept "community mental health."

In contrast, there was a significant "before" to "after" change in the Activity factor in the direction of perceiving the concept "community mental health" as connoting more positive activity (p beyond .025 level). But this held for the first year group

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1. Schulberg, H.C., and Baker, F., The Meaning" of Community Mental Health, June, 1967; mimeographed, Harvard Medical School, Cambridge, Mass.

only; for although the second year group showed changes in the same direction, the difference was not statistically significant. An analysis of co-variance indicates that this difference between the first and second year cannot be attributed to differences between the two years in the programs offered.

Finally, the participants from both years showed a movement in the direction of seeing the concept "community mental health" to be more potent, although this shift was of borderline statistical significance (p betwwen .10 and .05 level). However, since the two groups were not statistically significant from each other initially, they were combined for a statistical test of the significance of change. This test justified the rejection of the null hypothesis, (p beyond the .05 level) and indicates a shift towards seeing the concept as having more potency.

2. Acceptance of the Community Mental Health Ideology.

In order to measure any change in the acceptance level of community mental health ideology over time, an instrument developed by Baker and Schulberg was used.[1] This instrument is made up of five sub-scales, each presumably measuring a separate aspect of community mental health conceptual categories.

The first category is called "population focus." It represents the view "that the mental health specialist should be responsible not only for individual patients with whom he has contracted for treatment, but for the entire population of both identified and un-identified potentially sick members in his community." The "before" to "after" results are different for the two years of the project. During the first year there was a significant shift in attitudes towards a more population focus; during the second year there was a very slight shift in the same direction, but it was not statistically significant. Analysis of covariance (p= .02) indicates that such a difference can be accounted for by the "differential treatment" of the second year group.

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1. Baker, F., and Schulberg, H.C., Community Mental Health Journal, 1967, 3 (3), 216-225

The second category is "primary prevention." This category involves the "concept of lowering the rate of new cases of mental disorder in a population by counteracting harmful forces before they have had a chance to produce illness." Here again the results show interesting differences for the two years. During the first year, there was a shift in attitude towards "primary prevention," but it was not statistically significant. During the second year, there was a shift in attitude away from primary prevention, which is statistically significant. An analysis of co-variance performed on these data indicate that the differential "treatment" of the groups for the two years can account for the differences found. One possible explanation of these rather paradoxical findings is that in both years the participants had, prior to the beginning of the project, ranked "lack of preventive strategies" as being high in terms of what was perceived as being the major problem areas in local community mental health. For example, during the first year the participants ranked this problem as second highest; and during the second year it was ranked highest. Thus, it may well have been that one result of the training project both years was to reduce the relative saliency of attitudes regarding "primary prevention" relative to other, perhaps less common, attitudes regarding factors seen as relevant to community mental health.

The third category is "social treatment goals." This involves the "belief that the primary goal of treatment is not to reconstruct the mental patient's personality, but rather to help him achieve social adjustment in an ordinary life situation as soon as possible. Once again the results from the two years differ. The "before" to "after" change during the first year indicates that there was a shift in the direction of greater acceptance of "social treatment goals" of borderline significance (p between .10 and .05 level). During the second year there was no significant shift. Analysis of co-variance indicates that this difference cannot be attributed to differential "treatment" effects.

The fourth category is "comprehensive continuity of care." This category involves the "view that here should be a continuity of professional responsibility as the patient moves from one program to another in an integrated network of care-giving service." Here, by contrast, the results from the two years are consistent: in neither case was there a significant change in attitudes.

The fifth and final category of the Baker-Schulberg Scale is "total community involvement." This category involves "the belief that the mental health specialist is only one member of a group of community agents caring for the mentally ill, and that he can extend his effectiveness by working with and through other people." Again, the results from the two years of the project differed. During the first year there was a change in attitude in the direction of greater acceptance of this concept that was highly statistically significant (p= .005 level). In contrast, there was no significant difference during the second year. Analysis of co-variance indicates that this difference in results can be accounted for by differential "treatment" during the two programs.

If one combines all five categories of the Baker-Schulberg Scale for each of the two years to obtain a total score, the differences between the two years of the project again become apparent. For the first year there is a significant "before" to "after" total change in attitude in the direction of a greater overall acceptance of the concepts of community mental health (p= .005 level, summing all category scores). Using the same total scores for the second year, the difference in the "before" to "after" scores is not significant. An analysis of co-variance using the total scores indicates that the difference in results between the two years of the program can be attributed to differences in "treatment."

One possible explanation for the rather inconsistent results in terms of "before" to "after" changes using the Baker-Schulbert Community Mental Health Ideology Scale is the fact that the participants in the second training project had high initial scores

as compared to a large sample used by Baker and Schulberg to standardize their instrument. That is, it may be that the present groups had such favorable initial acceptance of the community mental health ideologies, as measured by the Baker-Schulberg Scale, that it would have been difficult to increase their favorableness. Evidence seems to suggest that this might be the case.

For example, the overall mean score for the large (N= 484) group of mental health professionals was 5.57. The initial mean score for the participants in the first year of the project was 6.12 which rose to 6.32 (a statistically significant change, as indicated above); for the second year the initial mean score was 6.19 which dropped very slightly to 6.14 (not statistically significant). In only one case out of 12 possible initial means (5 initial scale means plus an overall means for each group) was the mean of the present program's participants <u>below</u> that of the Baker-Schulberg large sample. This was the first year's initial mean on the "total community involvement" scale which was 5.76 as compared with the Baker-Schulberg sample's mean of 5.83. As might be expected, the "after" means for this group rose to 6.15 for this scale, a statistically significant change. The initial mean for the second year group on this scale was 6.32 which dropped very slightly to 6.31 (not statistically significant).

3. <u>Attitudes About Local Community Mental Health Problem Areas</u>.

Prior to the beginning of both the first and second year training project, a list of 22 possible local problem areas in community mental health efforts was given to each participant (See below). The participants were asked to check the five problem areas that they considered to be "most important" to community mental health in the Cleveland area. The participants were free to add any problem areas not listed.

In terms of results, it is first interesting to compare the top ranking problem areas for the two groups of participants <u>before</u> going through the project. The top six "before" problem areas were:

22 PROBLEM AREAS

CODE: _____

OF THE FOLLOWING PROBLEM AREAS, PLEASE CHECK THE FIVE YOU CONSIDER TO BE MOST IMPORTANT TO COMMUNITY MENTAL HEALTH IN CLEVELAND. FEEL FREE TO ADD ANY AREA NOT LISTED.

_____ INADEQUATE FACILITIES

_____ GENERAL SOCIAL PROBLEMS

_____ WAITING LISTS

_____ COST OF PRIVATE CARE

_____ MANPOWER SHORTAGE

_____ INTERAGENCY COORDINATION

_____ INTERAGENCY COMMUNICATION

_____ EDUCATION OF LOCAL POWER STRUCTURE

_____ OVERLAPPING SERVICES

_____ HARD TO REACH FAMILIES

_____ CONSULTATIVE RESOURCES

_____ AMBIGUITY ABOUT SPECIFIC RESPONSIBILITIES

_____ IDENTIFICATION OF CLIENTS, PATIENTS

_____ INADEQUATE FUNDS

_____ UNEVEN DISTRIBUTION OF SERVICES THROUGHOUT THE COMMUNITY

_____ INCOMPLETED REFERRALS

_____ LACK OF SERVICES OR LACK OF AVAILABILITY

_____ PUBLIC APATHY

_____ LACK OF PREVENTATIVE STRATEGIES

_____ LACK OF KNOWLEDGE OF THERAPEUTIC TECHNIQUES FOR DEALING WITH UNDERPRIVILEGED CLIENTS

_____ MENTAL HEALTH PROFESSIONALS LACK OF CONSULTATION SKILLS

_____ LACK OF LEADERSHIP IN SOCIAL ACTION RELEVANT FOR MENTAL HEALTH

_____ OTHER (PLEASE INDICATE)

FIRST YEAR	SECOND YEAR
1. Manpower shortage.	1. Lack of preventive strategies.
2. Lack of preventive strategies.	2. Inadequate facilities.
3. Lack of leadership in social action relevant for mental health.	3. Lack of leadership in social action relevant for mental health.
4. Lack of knowledge of therapeutic techniques for dealing with underprivileged clients.	4. General social problems.
5. Inadequate funds.	*5. Manpower shortage
6. Inadequate facilities.	*6. Lack of knowledge of therapeutic techniques for dealing with underprivileged clients.

As can be seen, the overlap in the perceived top problem areas is considerable. Only "inadequate funds" and "inadequate facilities" appears in the top of the first year list but not in the second year; and, "inadequate facilities" and "general social problems" appears in the top of the second year but not the first.

The "after" top-rated problem areas for the two groups are as follows:

FIRST YEAR	SECOND YEAR
** 1. Lack of leadership in social action relevant for mental health.	1. Inter-agency coordination.
** 2. Lack of preventive strategies.	2. Lack of leadership in social action relevant for mental health.
3. Inter-agency coordination.	3. Inter-agency communication.
4. Inadequate funds.	4. General social problems.
5. Education of local power structure.	*5. Inadequate facilities.
6. Manpower shortage.	*6. Lack of preventive strategies.

Some of the "before" to "after" changes are worth commenting on. First, one of the aims of the project had been to stress the concept that, through <u>increased inter-</u>

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* Indicates a tie for fifth and sixth place.

** Indicates a tie for first and second place.

agency collaboration, much could be accomplished with the resources at hand, i.e., without additional money or manpower. It is interesting to note that during the "after" assessment, "manpower shortage" dropped from first to sixth place for the first year group, and from tie for fifth place to tie for eleventh place in the second year group. "Inadequate facilities" dropped from sixth place to a tie for twelfth place for the first year group, and from second place to a tie for fifth place in the second year group. In addition, "interagency coordination" for the first year group rose in ranking from a tie for tenth place to third place, while "inter-agency communication" and "inter-agency coordination" rose from ties for thirteenth place to third place and to first place respectively in rank for the second year.

Doing a better job with the resources at hand rather than looking for some "new magic" is also reflected in the drop in the "before" to "after" ratings for both years on "lack of knowledge or therapeutic techniques for dealing with underprivileged clients." These drops were from fourth to ninth place for the first year; and from a tie for fifth place to a tie for eleventh place for the second year.

Finally, it is interesting to note the differential "before" to "after" change for the two groups in their ranking of "lack of preventive strategies." For the first year, the ranking remained high, going from second place to a tie for first place. For the second year group, the rank went from first to a tie for fifth place. These findings are well reflected in the Baker-Schulberg Scale (described above) where the shift in the category "primary prevention" was insignificant for the first year, and was actually away from "primary prevention" for the second year group.

Finally, there was a notable change in the first year group in the rank of "educatio of the local power structure" from a tie for tenth place to fifth place. While this same problem area was not salient for the second year group, the same attitude may be present in the relatively high ranking of "general social problems" (fourth place both "before" and "after").

4. Change in Perception of Local Participating Agencies Seen as "Most" and "Least" Directly Involved with Community Mental Health.

During both the first year and the second year of the project, the participants were given a list of participating agencies for that year and were asked -- both at the beginning of the year and at the close -- to select "the three that you feel are currently most involved with community mental health." Eleven agencies were rated during the first year and 19 were rated the second year. There were four agencies which were rated both years of the project.

Perhaps the most relevant "before" to "after" changes in terms of the goals of the training efforts were those having to do with agencies that are not traditionally seen as having a direct connection with mental health. For example, during the first year, a community center which was not well known to the participants shifted from being seen as tied for fifth place on "most directly involved" and fourth on "least directly involved" to second on "most directly involved" and tied for tenth place on "least directly involved" by the end of the project. It is interesting to note that knowledge of this agency's work became better known in the professional community, so that at the beginning of the second year, this agency was ranked first (out of 19) on "most directly relevant."

The most striking change in perception regarding an agency occurred during the second year. This agency was a multi-purpose service center in an area of rapid transition supported by the local Council of Economic Opportunity. It rose from being tied for twelfth place on "most directly relevant" before the project began to second place by the end of the project.

Several agencies who are traditionally seen as being closely related to mental health were the objects of changes in perception on the part of the participants as a result of the project. For example, during the first year, two agencies were tied for seventh place on "least directly involved" prior to the training project. One was a privately supported agency serving youth, largely on an individual treatment basis.

The other was a university-based institution devoted primarily to problems of mental retardation. After the project, the mental retardation agency moved from its position of a tie for seventh to first place on "least directly involved" with community mental health. The agency serving youth moved to being third on being "least directly involved."

There were similar findings during the second year. A visiting nurse agency moved from a tie for second place on "most directly relevant" to a tie for ninth place after the project; and a private in-patient treatment center for disturbed children moved from a tie for eleventh place to a tie for eighteenth place on "most directly involved."

It should be noted that the "before" to "after" changes on the variable "most directly involved" were not always consistent with the changes noted on the variable "least directly involved." One obvious reason for this is that the participant group as a whole, prior to the project, was often in disagreement about the relevance of a particular agency. A typical example of this was the local County Welfare Department. During both years the "before" to "after" change on the rating of "most directly involved" in community mental health was negligible, but the changes in "least directly involved" were striking. During the first year there was a drop on this variable from being tied for second place to a tie for eighth place; but during the second year, there was an increase from a tie for seventh place to fourth place.

As has just been noted, the consistency with which the participants saw an agency decreased as the project progressed. For example, a local state mental hospital whose plans to move more in the direction of being community-oriented throughout had been widely discussed, but had not yet been successfully implemented, moved from a tie for sixth place to a tie for fourth place by the end of the project on "most directly involved." At the same time the attitude of the participants had moved from a tied rank for thirteenth place to seventh place on "least directly involved."

On the whole, the project staff has felt that the changes in attitude reflected by the responses to this instrument have reflected more realistic perceptions on the part of the participants regarding the relative actual direct involvement of the various participating agencies with community mental health. This is seen as one of the more important results of the project in terms of increasing inter-agency collaboration.

COMPREHENSIVE COMMUNITY MENTAL HEALTH TRAINING PROJECT

FOLLOW-UP REPORT FROM PARTICIPANTS:

The staff report for this year must include a report of changes that have occurred as a result of this program. These changes may be within the person, within the agency, between agencies in the program, or between agencies in the program and others in the community. By "change" we mean any activity that has occurred or is being contemplated that, in your judgment, was stimulated either directly or indirectly by your participation in this project.

If you will fill out the following form, we, the staff, will have more accurate and up-to-date information on which to base our summary. Please be specific; i.e., briefly describe the "new thing."

I. WITHIN AGENCY CHANGE:

A. Building organizational effectiveness: This would include programs or exercises used to improve communication skills among staff; improved collaboration or communication between departments; new or improved interdisciplinary planning, sharing of responsibility, etc.

B. New delivery of service strategies: New treatment strategies planned or adopted, new role functions for personnel; development of teams and team responsibility for service, etc.

C. Manpower shortage: Use of and/or training of persons within agency to take on new functions or roles.

II. BETWEEN AGENCY CHANGE

A. Referrals: Improvement in referral process providing better continuity of care for client. Please list those specific agencies with whom this has occurred.

B. New Services: Planned or established as a result of collaboration between agencies in this program. If this has occurred with agencies outside of this project, but was, in your judgment, stimulated by your participation in this project, also cite.

Use reverse side if necessary.

C. Community involvement: Reaching new groups in the community via consultation, new services, training of personnel in other agencies, etc. This would also include visits to other agencies you had not previously visited.

III. INTRAPERSONAL CHANGE

The most significant kind of change, and one which may be most important over time, is that which has occurred in you. These changes may be related to your concept of community mental health, to your perception of yourself or other persons, agencies or professions whom you met in this project, or to your perception of your agency and its potential role in a comprehensive community mental health approach. This change may also be more of interest or excitment in your present job or role, or the reverse, i.e., more dissatisfaction with what you are doing. Intrapersonal change also means wanting some change either in yourself and/or others, even if you cannot do this alone, or don't know how to bring this about.

IV. Please check the aspect of this program that you believe was responsible for the changes that occurred. Comments from you would be most helpful.

_____1. Information received, i.e., the content of the lectures, readings, etc. Please specify the content area that was most relevant for you.

Use reverse side if necessary

_____ 2. The workshops and group dynamic exercises. Comments:

_____ 3. General psychological-social "climate" that prevailed when group met. Comments:

_____ 4. Other factors. Comments:

Use reverse side if necessary

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